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Making decisions in mental healthcare: a phenomenological study

PhD Thesis

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Chapter 1: Introduction

Introduction

In the UK, Government policy and professional practice now require that people who use mental health services should be involved in making decisions about their care and treatment. However, involvement can have different meanings and conflicting rights and responsibilities are expected. Practitioners in various professional disciplines, the people who use their services and family carers all employ different conceptual models (Colombo, et al., 2002). These conceptual models are drawn from medical, psychological and social understandings of distress, so that practitioners struggle to find common ground in their approaches (Donnison, et al., 2009).

Practices from commercial enterprise are introduced into healthcare commissioning systems. This is a form of decision-making framework that is driven by wider institutional demand for technical rationality and efficiency (Speed, 2007). While notions of consumer choice and empowerment are promoted, there is little evidence that people are gaining more practical or meaningful choices in their encounters with mental health service providers (Hui & Stickley, 2007). Practitioners can also experience distress as their autonomy is lost when they deliver predefined forms of care or treatment, with limited time and resources (Acker, 2010).

This study is conducted within a tradition of phenomenological research and while an established methodology is employed, two innovative steps are taken. In the first of these it is recognised that people continue to make decisions no matter how limited their options appear (Frankl, 1959/2004). But also, that this is still the case even

when it is thought that a person's capacity for reasoning is impeded by biological disease, psychological distress or social pressures. Secondly, the study responds to Edmund Husserl's original call for us to ask 'what is experienced' before asking 'who is experiencing' (Langdridge, 2007). The study brings participants together in groups for the process of analysis, but no assumption is made that the experiences this reveals might only be encountered by one type of person.

When choices are lost people are still seen as agents who either seek further opportunities or just give in. They can endure abuse within the narrative identities of 'victim' or 'survivor,' for example, and they will be held to account differently in each case. To understand them as lacking control or removed somehow from their experience is to strip them of their moral responsibility and that would make them less than human (Beauvoir, 1997; Sartre, 1969). We can only observe mental illness, psychological distress or social constraints through the manner in which each individual experiences them. These phenomena might have an existence in the world out there but we only know them through the manner in which a person makes sense of them.

Other forms of research explore the nature of mental illness, conceptualising a lack of rationality or verifying a loss of control or opportunity. The unique human agent is set aside in objectification and measurement, making the problem more real. Cause and effect relationships are proposed which imply that 'normal' people are always rational and in control, while others are afflicted by their problems and left powerless. This study does not, however, dismiss these ideas and all views are considered equally.

Questions can then be asked about the consequence for participants, if one view were adopted rather than another.

In recent years Government policies have been introduced with the aim of redressing perceived imbalances in the exercise of power in mental healthcare. A loss of power is not only understood as a consequence of suffering from an illness, but is also associated with competing interests. Practitioners might act to advance their professional interest rather than attending to the needs of the people who are seeking their help. Initiatives such as ‘Personalisation’ (Department of Health, 2008), for example, divert funds from services that are run by professionals to give them to the people who need help, so that they can purchase that help from whomever they choose.

Recent Government policies have imported the structures of commercial enterprise, so that people who need help might be seen as customers who can exercise choice, maintain control and hold power over others. But is freedom enhanced by promoting consumerism; where people can only purchase one product or another? If people who use mental health services are understood in this manner they can more often be held to account for their problems, being viewed as investing their money wisely or unwisely.

When people do not agree as to how distress should be understood or responded to, someone who is ill might be thought of as incapable of helping themselves so that they have a right to receive treatment, even if they do not want it. But people are still expected to take reasonable steps to manage the difficulties they face and to avoid

falling ill if they can. Decision-making is commonly thought of as a rational process in which a person acts to advance their interests, working towards pre-determined goals in competition with others. But while distress is then often associated with an inability to contain emotions and impulses, at the same time, calculated self-interest can lack spontaneity as if we are not really free.

The notion of freewill is complex and much debated. When people take up employment in mental healthcare, for example, they are obliged to follow Government approved professional guidelines and protocols, rather than making their own choices. In philosophical theory, it has been suggested that this giving up one's own freedom is necessary so as to gain the regulation and protection of a higher authority (Thomas Hobbes, 1651/1996). In this understanding, our individuality is forged through an enquiring and personal encounter with the world (Benwell & Stokoe, 2006); while this individual advancement is always achieved in completion with others. Then, in maintaining the order of society, the will of self-seeking individuals must be managed. Within a democracy, however, it is still thought that everyone makes decisions in their own interests. Also, economic growth depends on everyone acting to gain advantage and thereby contributing to society. People who are diagnosed with mental health problems might, however, be thought of as disadvantaged and ideas about empowerment or social inclusion are often promoted. It is implied that those who claim welfare benefits should be encouraged to take paid employment, but this could mean that they must also give up freedoms to become part of society.

Other studies in mental healthcare have grouped participants as if their experiences are only meaningful within one narrative identity; ‘mental health worker,’ ‘family carer’ or ‘mental health service user.’ Participants within these groups express similar understandings. These are presented separately, with no attempt to integrate conflicting opinions across the different groups. But in this study, a more complete understanding is sought. Unique life-worlds are revealed, but by attending to common aspects of our existence we can still say; ‘yes that is how I would feel, think or behave if I were in their situation. This is not a relativist approach as the reality of the world out there is not denied. It is accepted that our only access to that reality is through the limited, contrary, but also reflexive accounts of people who are encountering it.

The theories which underpin most psychological research have inherited an understanding of decision-making in which our personhood is viewed as primarily a calculating thinking self (as described by Rene Descartes (Langdridge, 2007)), while our encounter with reality is direct and only mediated by our senses (as described by Immanuel Kant (Pippin, 2005)). However, these ideas create divisions in our understanding of the person, so that rational thought is now viewed as separate from bodily emotion and social context (Burkitt, 1999; Langdridge, 2007). Meanwhile advances in technology emphasise the value of rational and systematic decision-making. These are the means by which we are able to understand and control the natural world and promote our own interests. But then, perhaps this rationality has got beyond us as our embodiment in a social context has become a natural phenomenon which we now attempt to measure and control through the technical practices of mental healthcare (Foucault, 1967). We are perhaps all giving up our freedom, to

regulate our thoughts and emotions, so as to facilitate the rational processes of society.

By exploring different perspectives this study acknowledges disagreement and works with competing interpretations. It might be thought that this conflict would be resolved by cataloguing aspects of the world, 'out there,' by establishing the 'actual truth.' It could be assumed that in defining ways of being, a researcher is highlighting differences and building distinctions; as if people were stable objects with an interior that can be observed. However, this study works with narrative identities that are multiple, transient and contested. The phenomenological attitude is expressed by making no distinction between that which is inside or outside of the person. It is recognised that we are never complete or stable but always becoming. The nature of the person and the meaning of that which they experience are both forged in the one seamless moment; when a decision is made. Deciding that a threat is real, for example, will make our world more frightening and we will be less secure. Also, the degree to which others believe our decision is correct is not separate from their evaluation of us as an effective or ineffective decision maker, as rational or irrational.

Patient choice is emphasised in the N.H.S. (Department of Health, 2007) and again, the idea is promoted that people are competing against each other, that they are coming from different perspectives and promoting their own interests. However in examining different perspectives this study does not generate findings which can be verified as the one true version of events. No claim is made that a particular theoretical model is more accurate. It is not found that some participants are correct in their views while others are not. Findings will be presented that are truthful in the

sense that they validate the experiences of all participants. This is a form of truth which includes our human reality, that experience can be given different meanings, that confusion and conflict are central to our shared human existence.

Generally, when researchers address decision-making in mental healthcare, our ‘flawed biological condition,’ our ‘habitual negative thinking’ or ‘the social problems we face’ are all thought of as separate factors that can influence our choices. On one hand, processes such as imbalances in brain chemistry are emphasised, so that researchers neglect to theorise the psychological and social processes that are needed to overcome these problems. While on the other hand, emphasising social and personal vulnerabilities fails to recognise that we all live within the limits of an embodied state. Attempts have been made, therefore, to bring the biological aspects of our being back into our understanding at a political level (Cresswell & Spandler, 2009), or to connect experiences which are thought of as symptoms with social and political levels of analysis (Harper, 2004).

Despite these efforts to reconnect different aspects of our self, most often, rational decision-making is viewed as an innate human capacity which is undermined by disease processes, along with psychological or social problems. A person can be thought of as ‘not in their right mind.’ So that, when dangerous or seemingly random choices are made, medical or psychological treatments are sought, or the person is contained and isolated. This study asks how these forms of understanding influence our decision-making by setting established theory aside and attending to the experiences of participants who are involved in mental healthcare.

When a phenomenological attitude is informed by existential theory, difficult questions can be asked. For example, when people are understood to have a failing biological system, can they still feel involved in decision-making processes; do they experience themselves as disabled with limited capacity, or do they feel ‘differently able?’ How do healthcare workers experience processes of involving the people who use their services; how are processes of agreeing mutual decisions managed and can people be held to account when it is thought that they are unwell? If a person is excused from their obligation to contribute to society, do they thereby gain more freedom while benefiting from state welfare? Is mental illness only limiting their ability to make choices, preventing mutual agreements, or does it enable a more creative form of freedom? Or is greater freedom to be gained by making commitments to others and taking on responsibilities in the structures of our societies?

The study addresses many important questions of this nature. Interviews were conducted with participants, including people who are diagnosed as suffering from mental health problems along with support workers, family carers and professional workers; although many participants belong to more than one of these groups. Audio recordings of interviews were transcribed and subject to analysis, the results of which are reported in chapters 4 – 8. This Introduction Chapter starts to identify the limitations of existing research, using principles from existential theory to introduce the ideas and methods that are employed in the study. This discussion moves on to consider the manner in which rationality is an assumed natural human state, that mental health problems are naturally occurring scientifically observable phenomena. Principles from existential theory are reviewed so as to begin a process of questioning

these assumptions. This questioning is summarised to provide a justification for the current study.

Addressing complexity

The phenomenon of decision-making in mental healthcare is approached within a number of research traditions. Within some approaches, researchers might conclude that better decisions are made when people have more freedom, more resources and social support, suggesting mental distress is caused by social exclusion or oppression. Within other approaches it might be claimed that poor decisions are made because of the effects of a mental illness and the person has no understanding of this, so they must be detained and treated against their wishes; so resources would then be better spent on medical facilities. Other researchers might observe problems in cognitive processing and recommend that more psychotherapy should be made available. In these varying approaches, mental distress can be spoken of as a ‘disease’, as a ‘computer malfunction’, as a ‘repressed desire’ or as social stress, as if a person were a ‘damaged cog in a machine.’ An attempt is made in the current study, therefore, to set these models aside.

Phenomenological approaches have been employed to explore the experiences of participants in the setting of mental healthcare. But most often, only narrow areas of experience are explored, such as the experience of suffering from depression or being employed as a mental health nurse. The meanings these groups of people attach to their experiences are then treated as if they are stable understandings related to one category of person. Also, there are differences in access to power so that participants who are employed as workers might be able to impose understandings on others who

have no professional status or are thought of as vulnerable due to their mental health problems. This study is designed therefore to address this complexity by asking how conflict is experienced in the interpersonal aspects of decision-making.

Feeling free

Existential theory offers an understanding of decision-making in which common dilemmas and shared experiences are highlighted. Although no claim is made that experiences can be reduced to predictable or universal principles, there are aspects of our being which can lend meaning to existence reaching beyond the assumptions of our current cultural setting. For example, in considering decision-making in mental healthcare, some researchers have approached freedom as a vague inspirational notion, something we might or might not attain. In contrast, freedom can be understood existentially as presenting all of us with challenging dilemmas in the immediacy of our individual lives, whenever or wherever we live. But various practices in mental healthcare are spoken of as oppressive or emancipating, as if freedom can be granted or denied, or is more or less available to certain people in particular times and places. However, when people who suffer mental health problems are encouraged to return to work, for example, this is not a simple matter of either promoting or denying freedom (Spandler, 2007; Walker & Fincham, 2011).

Researchers in Cognitive Psychological have claimed that we could exercise more freedom and have more control if not for common faults in human decision-making (Kahneman, 2011). But this reasoning is based on a narrow model of decision-making as an aspect of a rational plan. People are understood as making choices at given points in time, moving forward towards their predetermined goals. It is then thought

that the nature of each person can be deduced through an analysis of the choices they make. Decisions and the people who make them are viewed, therefore, as rational or irrational within an external universal system of logic. It is even argued that our feelings can be enlisted in this rationalised form of being, through ‘emotional intelligence’ (Salovey, et al., 1993). But in contrast, existential theory suggests that our choices are meaningful only because they are mediated by the unique experience and emotional responses of the individual person (Kordes, 2009). The nature of our existence can be thought of as evoking uncomfortable emotions, demanding that we take up the nature of our being, to give our lives meaning (Merleau-Ponty, 1962).

In our day to day experiences we are always becoming as we struggle with the openness of our future, so that it is difficult to hold onto a consistent sense self or a preformed rational plan. Also, we face the conflicting and troubling understandings of others. We often find we are cut off from our emotional experiences, so that feelings are mixed up within us, or they are driving our actions through interpersonal flows of which we are only half aware. ‘Emotional intelligence’ then offers the promise of an enhanced form of rationality. However, while emotions can be healthy responses to a confusing world, they can also be toxic self-indulgencies which isolate and punish us or forms of enmeshed distress which fuel interpersonal conflicts (Ricoeur, 1960/1986). It is therefore, just a romantic notion that the logic of emotionally driven will is more true or authentic than the logic of an external or imposed rationality.

Implications

Mental healthcare is a setting in which forms of knowledge are applied, so as to give meaning to specific human activities, including the process of decisions-making.

Various understandings of our choices are promoted in which we are seen as in control of ourselves, as rational, or as suffering from mental illness. However, this knowledge is not just observing phenomena. It can have a regulating action, in defining and maintaining the rationality of individual choice (Rose, 1996). With greater emphasis placed on rationality as the preferred way of being, emotions are often thought of as undermining our decision-making and they can be associated with states of mental illness. Decision-making can, in contrast, be approached as a process which is underpinned by complex processes in which many factors at individual, interpersonal, group and societal levels all play a role, along with our biology, our physical environment and other aspects of our existence. Phenomenological research is needed therefore, in which this complexity can be addressed. Conflicting perspectives must be observed as an aspect of the phenomena, so that fluid and contested experiences of decision-making can be examined. This would be a more accurate and effective approach than just recording one or other point of view within a narrow theoretical model.

Bracketing off contested understanding in mental healthcare and observing the micro-scale processes of decision-making would enable an examination of personal freedom, asking how people are brought into being as individuals. Also, attention can be paid to the meanings that are attached to us in decision-making processes. Emotions can be seen as both an aspect of our embodied existence and as something which flows between people, due to our condition of always already being in the world in relationship with others. Most psychological researchers align with ideas and assumptions that are specific to our current social or cultural epoch and existential philosophy provides a means of understanding decision-making that reaches beyond

these limited perspectives. A phenomenological approach sets presuppositions aside and, by employing insights from existential theory, we are able to understand experiences as an aspect of common dilemmas which we all face in making choices.

Assumed rationality

Foucault observed that rationality is now our assumed normal state and subjectivities of the rational or mentally ill person emerge. Being accustomed to understanding ourselves as immediately and obviously rational, we are able to identify various states of irrationality through scientific enquiry (Foucault 1967). These mental illnesses are now viewed as normal aspects of the natural world which we can study, predict and manipulate. These ideas influence our experiences of decision-making and mental healthcare can be thought of as a regulating force ensuring that we comply with rational state sponsored choices and thereby limiting our freedom (Rose, 1996).

Power is enacted in the expression of these forms of understandings and the human capacity to choose is reduced. The individual person is understood as primarily an organised thinking self, which is separate from ‘bodily processes,’ ‘random thoughts,’ and ‘social context.’ It is thought that these separate aspects of our being can influence our decisions, causing errors in our judgements. A trend is noted in modern societies in which cognitive processes are increasingly privileged as having a more human and manageable quality. Decision-making is more often assumed to take place within the personal boundaries of just one individual thinker, while remaining open to examination and revision within a moral social order.

Rationality is not simply ‘imposed from above,’ but can be folded in to the interior of

being in processes of relating to others (Rose, 1996). The knowledge systems of psychology are freely taken up as our diverse desires and general dissatisfactions are molded into personal goals and disciplined motivations. Jurgen Habermas (1972) observes regulating forces acting in our everyday talk, as we develop explanations for our behaviour in interaction with others. For example, we construct rational understandings as we observe the advantages a person might gain through their actions, so as to account for the decisions which we then assume they have made. If there is no advantage, behaviour appears irrational and purposeless; the person's 'decision-making capacity' is placed in question. They feel a pressure to get a grip on themselves, to take responsibility and to work harder at disciplining themselves.

The calculating and individually aware social unit is now assumed in mainstream psychology to such a degree that an evolutionary history is proposed. Hastie & Dawes (2001) for example, introduce the topic of decision-making with an account of prehistory where individual survival is attributed to an ability to make good decisions. People are, therefore, often thought of as making rational calculations as if they are charting a course through their life. Emotions and pressures in relationships can be thought of as like a wind or a running tide which would push them off track. But when they are given accurate information they should be able to get back on course.

Contributing to society

Existential theory observes that each of us faces choices at different levels. At a basic level we can choose whether to take up a position in society as a rational decider, choosing that which others would expect in the routines and practices of our shared lives (Macquarrie, 1973). However, if we make this choice we might often feel that

we are trapped, unable to express our own will. But at the same time, the positions we have adopted grant us access to freedoms which are not available to those who seek an existence outside of society. Fitting in with the expectations of others enables access to shared resources. We gain the benefit of driving a car, for example, so long as we drive it in a manner that others find acceptable. We give up our freedom, in a similar manner, by working to pay taxes and thereby gaining the benefits of being part of society. It might be assumed, however, that a failure to contribute could only be caused by a loss of rationality. Those who suffer from mental distress are no longer given asylum, but are encouraged to engage in ‘meaningful activities,’ or otherwise contribute to our economy, as recommended by economists such as Layard, et al. (2007).

Critical Social Theory suggests that employment in modern societies is oppressive. While people might once have lived for pleasure, they must in a capitalist society be made to engage in unpleasant labour. Theodor Adorno wrote about the harnessing of erotic energy to the performance principle (Adorno, 1967). The ethereal rational decider is required in this capitalist system to have only a tenuous connection with the body, which functions as an ‘appendage of machines’ (Marx, 1888/1967). But it must be recognised that the opportunity to ‘live for pleasure’ in pre-industrial societies might have been even more limited. Although the metaphor of the ‘Iron Cage’ of capitalism inspires much debate, concerning our protestant ethical heritage (Baehr, 2001), our subsequent freedom from disease, squalor and ignorance is a significant gain. So even if the ‘ideal type’ of the rational decider does not really exist, this myth could be a very useful idea. Most people benefit from living in an economically advanced society in which this notion is promoted (Gergen, 2009).

There is great value in striving towards scientific understanding, efficiency and improving the quality of our lives through the control of our environment. However rationality is valued in modern economically driven societies to such a degree that irrationality must be silenced and separated. It is then through our efforts to turn the lens of scientific enquiry on our own embodiment, that the notion of madness becomes an ever present shadow hiding in our emotions, waiting to slip out unnoticed to sabotage our plans. We no longer segregate those who are thought of as irrational in asylums. Instead, everyone is subject to a form of discipline which regulates their behaviour.

We are taken by a kind of ‘instrumental rationality’ (Habermas, 1972), a way of thinking which closes our minds to the whys and maybes, only focusing on the how, the immediate goal, the efficient and expedient. We all want a ‘win win’ outcome, as presumed in Rational Choice Theory (Allingham, 2002). Meanwhile we are no longer in danger, as Eric Fromm suggests, of being enslaved. The risk is now that we will become destructive robots, having no means of making our lives meaningful in a rationalised and emotionless society (Fromm, 1955).

Implications

The lone rational decider is often thought of an agent exercising skills in reasoning, competing for survival in a harsh environment, at both a social and a practical level. This understanding of the human condition finds expression in common everyday understandings. It seems to be enmeshed in the structures of our modern societies where democracy and economic markets are built on the expectation that everyone will make rational choices so as to promote their own interests. However because

rationality is emphasised in this manner, our feelings are often understood as secondary, or even opposed, to rationality. Through the provision of state sponsored psychotherapy, many people are encouraged to manage their moods so that they can continue to work, pay taxes and then progress towards their own more limited possibilities.

Economically driven societies do not appear to generate adequate resources such as jobs or houses. Then, there are not enough person shaped spaces in these systems and our ways of being become distorted. Assumptions are made concerning the value of political policies such as ‘social inclusion’ (Spandler, 2007) and further research would be useful to explore the impact of this on people who are caught up in these forms of ‘social engineering.’ Critical Social Psychology employs models and develops understanding but this can neglect to observe the experiences of individuals. The accountability and agency of people, who might be exercising choice while contributing to the construction of their narrative identities, and that of others, might be missed (Hollway, 1989). Power is enacted in our society, where emphasis is placed on individual choice, accountability, risk and bureaucratic regulation, but this is still mediated by human experience. A study which explores this personal level of experience should be able to inform theory and policy.

A research study which addresses the topic of decision-making in mental healthcare might be expected to ask whether decisions can be made more effectively, so as to improve capacity and efficiency, either for the individual, for society, or for both. However, in the rush to manage populations, researchers might neglect to enquire into

the actual nature of the individual who is put under pressure to regulate their own behaviour, often beyond their biological capacity and in impossible circumstances.

Conclusion

We all struggle to give our lives meaning, facing dilemmas in either trying to conform to the expectations of others, or attempting to find our own path through life (Frankl, 1959/2004). However, if we fail to make a financial contribution to our society, this can be interpreted, not as a choice, but as an outcome of pathological deviancy such as mental illness or personality disorder. A stable, pre-existent and rational psychological self is assumed. This self is then thought of as undermined by emotionality, associated with disease processes, unhelpful negative thoughts or experiences of trauma and isolation. But the existential principles explored in this chapter suggest that it is the pre-existing social meanings of our culture which form our narrative identity and that a common emphasis on financial imperatives imposes a binary of rational or irrational means of experiencing ourselves.

This study is designed to recognise the complexity of decision-making so as to address the experiences of different participants on equal terms. Whether participants are given particular diagnoses or are employed as mental health workers, they will all be facing similar dilemmas. Principles from existential theory are employed in the analysis to observe how they are brought into being as deciders. They are constituted by the possibilities they face, but also by the facticity of the present moment in which these possibilities are limited along with a past that is given, so that they are always already in the world.

The choices we face can grant us freedom in the availability of possible futures. However, we lose all but one of these options when we decide, when alternative futures become the paths that we could have taken. It is from these situated positions that meanings are constructed and ways of being are enabled. The experience of making-decisions can pick us out from the crowd, imposing uncomfortable meaning on us and this illustrates the dilemmas we face in becoming a person who can be held to account. In contrast, we might struggle to give meaning to our life, or fully explore our opportunities, because the decisions we make turn out to be very similar to those of the other people around us.

The experientially grounded approaches that are adopted in this study stand in contrast with notions from mainstream psychological theory, in which a stable and pre-existent psychological self is assumed. It is noted that by importing the science based notion of causality and predictability into our understanding of human affairs, we frame decisions as points in a forward moving chronological process. People then become static pre-formed entities, choosing from a number of options set out before them, based on information gained from their past experiences. This might, however, be a way of being that is only enabled through the knowledge systems of psychology and psychiatry, within which it is known and understood (Barnden, 1997).

When attention is paid to lived experience it is found that decision-making does not often fit with a forward acting determinism. We are self-aware and we consider future possibilities, so that our choices can be affected more by what might happen, than by what has happened. For example, we sometimes face a dizzying kaleidoscope of possible futures, opening before us, so that we cling onto the security of the familiar

routine. Or we fail to envisage anything other than the unbearable sameness of each daily grind, leading inevitably to death, so that we will take any random opportunity to induce a different emotional state. The meaning that is given to our past is also variable as we rework our understanding of the decisions that we have made with hindsight. These understandings are often expressed in difficult conflicts in which others impose meanings and our sense of self can be hard to maintain.

The following chapter will review the background literature for this study while also observing the manner in which the various understandings which researchers employ are also taken up in popular understandings. It is these interpretations that feed everyday conflicts in which people are in dispute over the meanings attached to their choices and the implications this has for how they are understood or the value they hold in society. The methodology of the study will then be set out in chapter 3.

The analysis chapters, 4-8, start with an exploration of some common understandings of the nature of decision-making. These understandings are expressed as support workers and people who provide care to a family member talk about their experiences of decision-making processes in mental healthcare. The accounts of participants who experience fluctuating moods are then brought together so that these phenomena can be explored, revealing contrasting understandings. Attention is paid to the dilemmas people face in responding to their feelings, feelings which are prompted by their encounters with existence. The question of what might be an authentic response to this is discussed. The accounts of workers are discussed and the challenge of standing up to take a place in society as someone who makes a choice is considered, along with the contrasting difficulty we face, if we do not stand up, of having meanings imposed on us in a complex and contradictory manner. Some thought is given to practical

limitations on decision making where there are risks and a lack of resources, while also asking if choices can be thought of as individual decisions when they are governed by rationalised bureaucratic processes. Lastly, the possibility that we might make our lives meaningful in our own terms outside of society is discussed, as the accounts of participants who suffer from psychosis are explored. Is it possible, for example, for us to make choices separately from the meanings which others attach to us? The material across these chapters is then drawn together in the Conclusion Chapter.

Chapter 2: A literature review

Introduction

Decision-making in the setting of mental healthcare is a complex phenomenon and the approaches that researchers take when exploring this topic are often partial or contradictory. A number of studies focus on the decision whether to take antidepressants for example and this choice is conceptualised as something that happens in a doctor patient consultation. In contrast other areas of literature have developed around the themes of empowerment or ‘recovery philosophy.’ This promotes the idea that decisions should be democratic or inclusive and studies examine processes within mental health services, asking who has the ability to influence the outcome of decisions. Other studies explore the possibility that people might be helped to make choices that are more rational at an individual psychological level. Then there are researchers who examine functioning at a biological level, attending to the notion of ‘mental capacity’ and assuming that decisions would be rational if not for the influence of mental illness. Similar assumptions are expressed when researchers presume that complying with prescribed treatment is always the best choice. Some studies seek the most dependable means of achieving that compliance, with or without the agreement of the person who is treated.

Although it is important that research should be diverse and that researchers should attend to specific questions, it is perhaps unhelpful that conflicting assumptions are adopted in different studies. There is no clear overall understanding of what decision-making means for people in this context. The current study makes an attempt, therefore, to set aside presuppositions so as to explore the lived experience of

decision-making as it is encountered by people who are caught up in the interpersonal processes of mental healthcare. Theoretical models and professional interpretations do not only find expression in their original formulation but are taken up in popular culture, as the stories we tell transform the manner in which we understand ourselves and others. A phenomenological approach can deal with this by bracketing off models and formulations during the process of analysis, to observe the manner in which people express these ideas as an aspect of their experience. Care is also needed in the process of reviewing literature, to ensure that these models and associated assumptions are not adopted in an uncritical manner. Research traditions are explored therefore, by not only asking how they inform our understanding but also how they promote a limited perspective. An argument is made for a phenomenological approach which provides more holistic understandings.

The first section starts by examining literature from sociological or political research approaches in which notions such as ‘empowerment’ and ‘recovery philosophy’ are promoted. A brief account is given of the development of these ideas across recent decades, set in contrast with the biological and psychological understandings that were popularised within ‘traditional’ approaches. The ideas which these more established approaches inherit from the Victorian Asylum or Sanctuary Movement are still influential, but increasingly criticised by politically influenced researchers.

Studies are reviewed in the second section where the experience of being invited to take psychiatric treatment is explored. This starts with research in which participants are assumed to be rational individuals who might or might not be included in decisions. Difficult dilemmas are explored related to the meaning of suffering and the

limits of intention or agency. Studies are discussed where complex influences on decision-making are identified which reach beyond the clinic setting into the transpersonal areas of bureaucratic systems and intimate relationships. The possibility is considered that if psychiatric treatment only masks distress so that people can return to a stressful work situation or tolerate intrusive social relationships, then it is not life enhancing. This section then turns to literature in which it is assumed that some research participants are unable to make rational decisions over whether they should take psychiatric treatment or not. The practicalities of achieving compliance with this treatment are considered when those participants who do not willingly agree to take it become enmeshed in interpersonal pressures.

A third section explores the notion of ‘mental capacity.’ Government guidance asks mental health practitioners to take the view that if people are not suffering from mental health problems then they are free to make rational choices, moving towards their intended goals. In some areas of research it is observed that if a logical process can be identified in which a person’s choices are viewed as rational, then justification is provided for withholding services; the person is not incapacitated enough to qualify for help. Also, that person would be held to account for the consequences of their choices. These understandings are contrasted with literature in which decision-making is viewed as an aspect of situated and embodied states; so that notions of intent, calculation or self-interest are read back into situations. This reveals the manner in which the notion of an inherent rationality can ease the flow of bureaucratic processes. Rights and responsibility can be assigned and resources managed by adopting these ideas.

The last section reviews the influence of principles from commercial enterprise. Another change in mental healthcare is revealed within which an understanding of people as individual rational deciders is promoted. It is suggested that services have failed to achieve equity in mutual decision-making and significant differences in access to power continue to exist between professional groups, family members who provide care, and the people who struggle to maintain their mental health. Studies are then discussed where new commissioning arrangements are evaluated, where care and treatment are provided in a financially managed and time limited manner. These constraints are found to cause complex disputes. Where the task of reaching agreement had already been difficult, this literature suggests that disagreements now arise in which participants find that they are attributed with negative social identities and are held to account for outcomes over which they have little control.

Empowerment, recovery and associated assumptions

The Victorian Sanctuary Movement was founded on the belief that mental health problems are caused by the challenges of our encounter with a difficult world and that removing or shielding a person from that world would make them feel safe and contained. However a recovery philosophy has developed over recent decades within which this kind of containment is thought of as a stigmatising form of segregation, through which freedoms are denied. It is now more often assumed that it is an oppressive form of containment which causes distress and that it is only when a person is free to work towards their own goals and fulfill their aspirations that they will recover their mental health. The tradition approach of containing the person so as to treat their illness has not lost its influence however. Conflicting expectations around rights and responsibilities are often expressed in mental healthcare. Someone

might feel they have a right to choose their own direction in life and to be responsible for the consequences. But if they are understood to be unwell, they are then viewed as having a right to protection and treatment. Mental health workers have a responsibility to meet their needs so that they will receive treatment that they do not want.

Liberal political agendas promote the notions of empowerment and self-determination. This can mean that people who struggle to achieve self-reliance are left unsupported. A paradox can be observed in which people who do not want treatment have it forced upon them while those who seek support are turned away on the grounds that, if they are well enough to recognise that they need help, then they are well enough to manage without it. They are expected to take responsibility for meeting their own needs, even though resources are not easily found to enable them to do so. Meanwhile some people might resist the offers of help that mental health services extend to them, because accepting help requires that they maintain a form of self-regulation and that they conform to the expectations of others. It is clear therefore that complex tensions exist. There is a pressure to conform set against a right to self-expression and these experiences are mediated by different forms of understanding. A phenomenological analysis can trace the development of these complex ideas and observe the manner in which they are expressed as people make decisions in conflict with each other.

Asylum or empowerment

Many changes in mental health policy and service specification are introduced, although it is often observed that related changes in practice are more difficult to

bring about (Leamy, et al., 2011). Most people share ideologies of ‘hope,’ ‘empowerment,’ ‘freedom’ and ‘choice’ for example, but when decisions are made in mental healthcare, sharply opposing opinions or understandings are expressed, hindering agreement. Different healthcare professionals are trained to understand the phenomena of mental health problems in contrasting ways (Dombeck, 1997) and there are contradictory notions in commonsense or lay understandings (Read & Harre, 2001). This means that, as people tell their stories, immediate and troubling conflicts will occur. For example, one party might understand choice to be impeded by biological or cognitive-processing problems, which they believe to be occurring in the other person’s brain. At the same time the other person believes the process is impeded by a healthcare system in which resources are withheld by those who have more power, from those who have more need. Attempts to understand this kind of conflict are complicated by the manner in which these ideas appear both in the data which are studied and in the assumptions researchers bring in their analyses of those data.

Some confusion can be unpicked by tracing the development of conflicting ideological movements. Victorian asylums have closed in the UK, for example, but forms of knowledge from that Sanctuary Movement still remain influential. Other areas of theoretical understanding have developed under the headings of empowerment (Fitzsimons & Fuller, 2002) or recovery (Anthony, 1993). The idea is commonly promoted that people who use mental health services should be involved in making decisions about their care and treatment, but this is set against practices in mental health services which inherit much from the Victorian era (Skull, 1980). In a traditional form of understanding, it is often assumed that mental health problems are

caused by the challenge of living in a difficult world and that control and regulation will be gained through the containment of living within an institution. Imposing structure is thought to have a calming effect, reducing troubled and chaotic expressions of individual will.

The understandings of the Victorian Sanctuary Movement fit neatly with an approach which is often referred to as a 'biomedical model.' It is thought that a person who is suffering from mental health problems has limited 'insight' (Dolson, 2005), being unable to observe the influences which disease processes have on their decisions. It is also thought therefore that they are unable to control the malignant influence of disease processes and that they will not be safe unless medical treatments and various forms of containment or regulation are imposed. The medical practitioner's duty to treat the disease, with or without the agreement of the patient, is brought to the fore in this interpretation.

The ideologies that underpin psychological therapy also grant a degree of privilege to professional understandings. It is suggested, for example, that, because they are suffering from various forms of neurosis, people commonly repress aspects of reality. Maintaining strict boundaries in the therapeutic relationship is thought to be an important means by which reality can be imposed. It is believed that this will help the person who is being treated to maintain intrapersonal psychological coherence (Gravell, 2010). However, the process of making mutual decisions might be hindered when different parties are thought to have different levels of responsibility, knowledge, ability and rights; the expectations of the more vulnerable or naïve parties must be 'managed.' It is assumed that, because they are more capable, professional

workers have a responsibility to protect those who are afflicted by illness or psychological distress. These interpretations can also make it appear that those who suffer mental health problems have a right to treatment, even if they do not want it and this treatment is assumed to be the primary means by which their needs will be met.

The traditional ways of thinking about decision-making in mental healthcare, outlined above, have been challenged in recent decades, particularly within a movement which has come to be known as recovery philosophy (Anthony, 1993). In this philosophy, individual aspirations and ambitions are understood as driving each person along their own journey towards personal meaningfulness. It is suggested that people will only overcome their mental health problems when they take control over their lives; when they invest their energies in activities within their communities; when they enlist the support of others in taking steps towards their own goals (Deegan, 1996). This means that when people make mutual decisions within this philosophy, everyone is assumed to be equal in their understanding, in their responsibilities, and in their rights.

Choice is paramount in recovery philosophy, as it is in recognising one's personal freedom, in an individual struggle towards self expression and in overcoming difficulties through one's own efforts, that mental wellbeing is achieved. These ideologies borrow many understandings from the Civil Rights Movements of the previous century, particularly the notion of promoting social inclusion and equality for people who suffer a disability. It is likely therefore that there will be some incompatibilities between recovery philosophy and the use of mental health law, through which treatment or care are forced on a person, or when professional

interpretations are imposed within institutional systems. It is paradoxical that workers should try to give control back to a person, for example, by taking it away, or by giving them choice by limiting their options (Priebe, et al., 2005).

The ideological foundations of recovery philosophy can be traced back to pioneers such as Franco Basaglia (Basaglia, et al., 1987), who introduced democratic decision-making within mental health hospitals. In the movement he inspired those who use mental health services are considered to have equal ownership of - and responsibility for - resources which would otherwise be managed by professional workers and administrators; such as the hospital, its land and maintenance budget. All choices, from decisions about treatment, through to permission to take leave from the hospital, to practical tasks in the maintenance of the building, would be made by the whole community. Similar communal principles were expressed in the writings of R. D. Laing, who worked within 'therapeutic communities.' In the therapeutic approaches Laing inspired, mental health practitioners and the people who use their services are expected to contribute as equals to a shared attempt to make life meaningful and tolerable (Laing, 1969).

Laing's influence is perhaps most evident in his observation that what appear to be symptoms of illness might instead be understood as responses to our existence in a failed democracy, where family relationships are damaged. Similarly, Erving Goffman (Goffman, 1961) also observed that the behaviours of those who are being treated for mental health problems in hospital are not only understandable as symptoms of diseased biological processes, but can instead be seen as responses to their detention in that institutional system; responses which any of us might display.

The person's behaviour does therefore make sense, given the nature of their circumstances. In these forms of understanding it is not presumed that there is a neat divide between the biological or psychological nature of the person and the social circumstances within which they find themselves.

Self-regulation

Clinical Psychology researchers often attend to the individual's attitude towards their circumstances and their capacity for rational calculation (Danziger, 1990). Ideas are imported from Cognitive Psychology theory and therapists can align their approaches with recovery philosophy where the individual is understood to be making choices so as to attain their own goals. This is a step towards a humanist approach that is 'person-centred' and this can be placed in contrast with biomedical approaches which only attempt to treat symptoms, failing to consider whether this is useful or meaningful for the person who is suffering. The notion of the individual striving towards their own goals is now commonplace, along with the idea that emotions can be problematic, or an unwanted hindrance, or that 'self-monitoring' can enable us to avoid unhelpful thoughts. These therapeutic techniques might be seen, however, as a means of enabling individuals to adapt to untenable social positions, such as unrewarding and underpaid employment (Cromby, et al., 2007). These techniques can be understood as a means by which specific understandings are folded into ourselves, as we struggle with the experience of freedom in late capitalist social systems (Rose, 1996).

These forms of 'self-government' are explored in Critical Social Theory and the phenomena is summarised by Nikolas Rose (Rose, 1996). The modern self is obliged

to be free in the sense that all aspects of life are the outcome of choices made among a number of options. So the nature and meaning of each person is realised, in this ideology, through their decisions and justified in terms of their motives, needs, and aspirations. This also means that the technologies of psychiatry and psychology gain social power in liberal democracies, because they now share and promote this notion of the competent autonomous individual decider (Rose, 1996).

The ideas expressed in recovery philosophy overlap with notions expressed in popular psychological ‘self-help’ literature; so that concepts such as ‘stress’ have gained meaning as a danger against which we must take guard (Brown, 1999). So ‘self-regulation’ or ‘self-improvement’ is suggested and these ideas have a hold on us because they promise to restore and sustain the rational individual decider. Rose claims that psychiatry and psychology employ ‘technologies of individuality’ in the production and regulation of the person who is ‘free to choose’ (Rose, 1996: 100).

Academic and theoretical debate might have some influence on professional practice in mental healthcare, but it has generally been through the efforts of people who have experienced mental health problems that recovery orientated philosophies are taken up, albeit in a problematic manner (Le Boutillier, et al., 2011). For example, from the perspective of workers, compliance with medication can still be an assumed priority, so that a person centred understanding is neglected and an implicit threat of detention remains (Spandler, & Calton, 2009). Narrow interpretations are promoted, therefore, so that the notion of ‘individual self-discovery’ might be set aside in the rush to pressure the person who is struggling into self-regulation. Then, when workers turn their attention from the problematic illness to the problematic ‘noncompliant patient,’

particular narrative identities emerge which can perhaps be traced back to Victorian understandings of ‘the deserving and the undeserving poor’ (Dean, 1991). In these interpretations, it is not only rights and freedoms which can be transferred from professionals to ‘self-actualising’ sufferers, but responsibilities and duties are also loosened and shifted. Where treatment does not resolve symptoms or make people feel well, moral responsibility might be transferred to the patient, who is required to develop ‘coping strategies’, adopting particular ‘attitudes’ which are believed to enable a better management of their condition (Salmon & Hall, 2003).

Recovery philosophy implies that changes for the better should start with a compassionate understanding of the person (Spandler & Strickley, 2011). However, in modern societies it seems that individuals must make their own decisions and suffer the consequences; then if they flounder the state’s responsibility to extend care and treatment can be reduced (Baistow, 1995). So many Government policies and related publications pick up on the notions of empowerment and recovery, calling for those who use healthcare to be involved in decisions about their care and treatment, so that responsibilities can be passed back to them. There is, however, little sign that any significant degree of ‘power,’ or ‘freedom’ is actually granted, transferred, or taken up; or that people gain more practical or meaningful choices in their encounters with mental health service providers (Hui & Stickley, 2007; Speed, 2007).

Researchers try to clarify just what the notions of empowerment or recovery might mean for people who endure mental health problems and how services might be changed to include these meanings (Allott & Loganathan, 2002; Meddings & Perkins, 2002). It is noted for example that if practitioners are to take on recovery based

philosophies, then they will need to help people negotiate the complex and confusing systems of mental healthcare (Chinman, et al., 1999). A ‘disability rights’ ideology emphasises the responsibility beholden on the state to extend support to people, while paradoxically those people often find that it is difficult to take up this support (Biddle, et al., 1998). It is suggested that the Government constructed notion of ‘social inclusion’ is an unrealistic target and that whether it is their intention or not, there are people who remain on the fringes of society, apparently refusing to be treated, educated, housed, or rehabilitated (Scanlon & Adlam, 2008).

When workers struggle to negotiate mutual decisions with people who are diagnosed as suffering from mental health problems, opinions can become polarised between blaming the reluctant service user for choosing not to be helped and finding the service providers to be at fault for failing to care (Scanlon & Adlam, 2008). Choosing not to be helped is not therefore always an acceptable decision, particularly if someone is understood as posing a risk because of their failure to accept treatment. It is difficult to claim that someone has intent when their behaviour is seen as chaotic and irrational. It is then likely that the meanings found in the more traditional approaches to mental healthcare will again be expressed. Workers can struggle with the burden of this responsibility, particularly when they are expected to ensure that these reluctant service users are constantly well, happy and safe; always making rational decisions (Reid, et al., 1999).

Summary

Mental healthcare is a setting in which conflicting forms of understanding are expressed. It might be claimed that mental health problems are caused by the

challenges of a difficult world or by the isolation and stigma of being removed from that world. Conflicting claims are associated with different expectations around rights and responsibilities and person might feel they have a right to choose their own direction in life and to be responsible for the consequences. However, if they are thought of as unwell, they are treated and protected by professional workers who have a responsibility to meet their needs, whether this is wanted or not.

A need for sanctuary or asylum is denied in liberal political philosophies, but people can struggle to achieve self-reliance when left unsupported. They are ‘empowered’ but lack the resources they would need to meet their needs. They might resist offers of help because they would be required to self-regulate and conform to the expectations of others. There is a tension between the pressure to conform and a right to self-expression or freedom of choice.

The current study is designed to explore experiences of making choices so as to ask if people who suffer mental health problems are involved in decisions about their care and treatment. A phenomenological approach which attends to the existential dilemmas people face in making choices could shine new light on the tension and conflict in this setting. However where phenomenological approaches are employed, decision-making has been approached in limited contexts, such as when an individual experiences depression, or when they consult their doctor about taking antidepressants. These areas of analysis are reviewed in the next section.

Deciding to take medication

Research studies are conducted in which the decision to prescribe antidepressant medication is explored and many are included in the meta-analysis conducted by Malpass, et al. (2009). It is often assumed in this area of literature that the person who is invited to take treatment is a rational and capable individual, who might or might not be included in decisions. Specific decisions can be considered within this framework such as when to stop treatment and what the decision to continue with treatment means for the person's social identity. These dilemmas are considered in this section and difficult questions are identified concerning the meaning of suffering and the limits of intention or agency. Other influences on decision-making are identified reaching beyond the clinic setting in which it is often assumed that choices are agreed.

Phenomenological studies observe that the ability to exercise personal volition a core aspect of being, but when medications alter moods or thoughts, it is not clear whether this is enhancing a person's agency or not (Stevenson & Knudsen, 2008). This section will move on to ask if treatment is empowering when it enables someone to return to a stressful work situation, or when it enables them to tolerate distressing social relationships. Then other areas of literature are discussed where the question of whether someone is able to make the decision to take treatment or not is considered. This area of literature enquires into the practicalities of achieving compliance with treatment, with or without the willing agreement of the person who is suffering. When these matters are examined from an ethnographic or qualitative research perspective, a potential for complex and enmeshed relationships is observed in mental healthcare

(Szmukler & Appelbaum, 2001). Research approaches which deal with complexity are therefore useful in gaining understandings of these matters.

Choosing treatment

The decisions to prescribe or take antidepressant medication are explored by Malpass, et al. (2009). This meta-analysis brings material together in which subjective experiences of depression and its treatment are considered. Participants who face dilemmas as to whether to take treatment or not find that they can manage the difficulties of their lives more successfully when they do, but this creates uncomfortable questions for them related to what this means for their identity and their freedom of choice. Understanding themselves as somehow flawed and unable to make good choices without medical intervention feels stigmatising. There is also a dilemma over the question of control as it can be difficult for people in this situation to know whether they are ill or not and whether they need to continue taking treatment (Knudsen, et al., 2002). People in this situation face a paradox as their feeling of being normal is achieved only when they take medication, a behaviour which highlights their sense of being different from others (Garfield, et al., 2003).

When consulting a medical practitioner there is the problem of a perceived imbalance in knowledge and power. Questions arise around the idea that people should ideally be equal and free in their encounters with each other and if they are not, how could this be achieved (Deegan & Drake, 2006). Very often however, it seems that equality is assumed, but then, little attention is then paid to actual differences in roles and contrasting forms of accountability between expert and lay positions (Wirtz, et al., 2005). It is observed that Government policy promotes an 'informed choice' model in

which the doctor gives information and the patient chooses; in practice, however, it is a paternalistic model which is most often expressed: ‘doctor knows best’ (Elwyn, et al., 1999). Medical workers are likely to frame their encounters with patients in a manner which will make expertise and medical procedures central, obliging the patient to comply with treatments (Goodyear-Smith & Buetow, 2001).

Enmeshed in systems

Decision-makers in mental healthcare are not necessarily arguing from their own personal perspectives and they can be understood to be taking up positions in established conflicts. While decisions might often be made by just one practitioner and their patient, the process will be influenced by the many diverse facets of the setting, such as professional codes of conduct, economic pressures on organisations, legal actions, available technologies and treatments. Professional workers do not only have a duty to meet the needs of the people they are trying to help, they must also serve the professional body to which they belong, along with their employing organisation (Salmon & Hall, 2003). So each decision will probably be linked to many events and evolve over multiple encounters (Rapley, 2008).

People who seek help from a medical practitioner are also enmeshed in complex social systems (Granek, 2006). When a phenomenological analysis is employed, it is reported that people often feel emotionally driven in their relationships, feeling ‘overwhelmed’ or ‘lost’ prior to taking treatment. They described the medication as helping them in creating a sense of distance from other people, by reducing, not lifting, the intensity of their emotions; *“Participants now experienced previously troubling situations from just this “distance” or “perspective,” rather than being*

“sucked into” them. Events that would have “gotten to” or even “suffocated” them no longer even “touched” them, and thus participants found themselves able to “face the world” without being overpowered.” (Teal, 2009: 24). It seems that people can learn to use antidepressant medication as a kind of anaesthetic, to overcome the difficult emotions which contact with other people causes them to feel.

Dampening down emotional distress might help people cope and a biomedical interpretation would frame the problem as a disease process; something to do with ‘chemicals in the brain.’ However, if the understandings promoted with humanistic and recovery philosophy approaches are adopted, this can only be viewed as a temporary or partial solution to the difficulty of being-with-others. People who use antidepressants in this manner might feel that chemically altering their emotions is an inauthentic response to life experiences and some form of self-development or expression of personal agency would be more healthy (Stevenson & Knudsen, 2008). But in contrast the decision to manage life problems through the use of medication could be promoted as the action of a rational decider, a person who is empowered because they are taking control over their emotions; emotions which were previously experienced as overwhelming (Rhodes & Smith, 2010).

The ‘mind over mood’ message promoted by Cognitive Behavioural Therapy (Padesky & Greenberger, 1995) suggests that emotions can be ‘unwanted’ and somehow a problem to be overcome. They might at times provide useful ‘feedback’ informing our rational understanding. However they are still understood as unpredictable and dangerous so that the control of a rational decider is needed, as in the notion of ‘emotional intelligence’ (Salovey, et al., 1993). The separation of our

being within various biological, psychological or sociological understandings influences our understanding of ourselves, as expressed in the stories we tell and in what others say about us. For example, are we rational or driven by our emotions? Are our emotions telling us something important and are we free to respond as we choose, or should we take treatment so that we can continue to work and contribute to society? These contrasting understandings are associated with different attitudes and associated notions of blame or stigma. Theoretical models at biological, psychological and sociological levels promote ideas about causality which are taken up when people try to make sense of their experiences.

When biomedical understandings are promoted, such as the idea that depression can be thought of as ‘just like any other illness,’ then it might be thought that this would reduce the stigma people experience; but this is not found to be the case (Goldstein & Rosselli, 2003). If mental illness is explained as an outcome of biological and genetic causality, members of the public tend to express negative attitudes, including perceptions that ‘mental patients’ are dangerous, antisocial and unpredictable; they do not attribute blame, but would not seek to develop a social relationship with the person (Read & Hare, 2001). In contrast to this, if psychological explanations are given, such as the idea that people can form the habit of negative thinking, there is then an increased tendency to blame and seek social distance; but when social or environmental explanations are given, such as distress being caused by trauma or isolation, people are more sympathetic and are willing to form social attachments (Goldstein & Rosselli, 2003). Within a social explanation, people might be understood as struggling to express their agency due to external pressures, but they

are still viewed as capable of taking control. Other people are then more likely to gather round to offer support.

An incoherent self

Psychological and biological forms of understanding can be promoted in which depression is seen as something which is separate from the person's life context. It might be assumed that life should make us happy and if it does not then there is something wrong with us (Pilgrim & Dowrick, 2006). Extreme risk-taking behaviours such as attempts at suicide are often understood as the outcome of a diseased biological process, rather than an understandable response to difficult life-experiences. People are then using these understandings to adopt an internal split, giving some of their behaviour the meaning of 'not under their control.' People who are addicted to substances, or those who are troubled by intrusive ideas about harming themselves, for example, can feel that they do not have full control over these behaviours.

It is observed that conflicting understandings open up a division within us between our biological process, our mind and the social context (Burkitt, 1999; Langdrige, 2007; Latour, 1991; Salmon & Hall, 2003; Williams, 2000). But, in contrast to this, people who are diagnosed as suffering from a psychotic illness do not seem to use a dualist model to understand their experiences of this condition. Psychosis is a phenomenon which can be associated with experiences of a loss of volition, or of being controlled by others, but when people are struggling with these experiences, they do not necessarily make a distinction between the illness and their wider lives or their sense of self in spiritual or moral terms (Kinderman, et al., 2006). The 'illness,'

its treatment and associated side-effects are reported as a seamless experience; as an embodied state (McCann & Clark, 2004). This means that in applying a biomedical understanding, practitioners seek to promote the concept of ‘insight.’ This is the idea that, while the experience of suffering from a mood disorder or psychosis can be very real, people should understand that their thoughts and feelings are just symptoms, that they have no real meaning in their literal terms.

Because psychosis is rarely identified by the person experiencing it as an illness, as separate from their being and their life context, they do not always seek treatment. They often fail to continue with treatment when it is prescribed. An onus is then commonly placed on mental health services to ensure that treatments are taken and this limits the degree to which agreements can be freely negotiated (Dolson, 2005). In order to avoid the legal consequences of being seen to have ‘failed in their duty of care,’ workers will either try to influence the decisions people make, or take action against their wishes (Szmukler & Appelbaum, 2001). ‘Concordance Models’ suggest that people remain on treatment while their relationship with their medical practitioner is harmonious (Vermeire, et al., 2001). In these models, when the patient stops taking medication, it can be argued that they are making a rational decision (Donovan & Blake, 1992). But again, workers can use dualist ideas about separate psychological and biological selves. They can claim that there is a permanent impairment in reasoning a; ‘lack of insight’ (Dolson, 2005). Alternatively they can use psychological knowledge to observe that the service user is ‘in denial,’ refusing to accept that they have a need for treatment.

When a diagnosis of psychosis is given and there are questions over the person's safety, the responsibility to ensure that compliance with treatment is maintained is commonly understood to be held by mental health services. Szmukler & Appelbaum (2001) describe five levels at which workers in these services might ensure that people are taking prescribed medication. There is persuasion as an 'appeal to reason' and then there is the application of 'interpersonal pressure' (in commercial terms this would be 'hard selling'). The next step up from this leverage is the offering of inducements, where workers might offer to use their expertise to help service users gain resources, such as housing and welfare benefits. This provision of help is also observed at the next level, where there is a threat, that, if service users do not cooperate with treatment programmes, then support and help will be withdrawn. All these tactics seem to be imported from practices in the commercial world but in the last level, legal powers are used to impose treatment. Meanwhile, although it is compliance with treatment that is highlighted here, workers might also use these strategies to get service users to abstain from using alcohol or illicit substances, or to encourage them to attend rehabilitation day programmes, or adapt their life-style in other ways, such as seeking paid employment.

Coercion and dependence

When workers resort to the use of complex interpersonal pressures, to ensure people who use their services comply with treatment, it is clear that relationships become entrenched and conflict ridden. Questions would be asked about the competence of workers if people for whom they are thought to be responsible were to engage in risky behaviours (Gaitskell, 1998). Conversely, those who are treated by these services report their concerns that if they upset their workers, by refusing to accept prescribed

treatments, then various supports would be withdrawn (Monahan, et al., 2005). These forms of support include their housing, support in their encounters with the criminal justice system, their access to welfare benefits, their freedom not to see psychiatric workers and their freedom to have contact with their children, or to hold childcare responsibility for them. The paradox here is that although an ideology of choice and empowerment is promoted, reciprocal and interdependent relationships are likely to develop where various agents in mental healthcare seek to predict and control each other's behaviours.

Although mental health practitioners might have an interest in the beliefs and personal disposition of their patient, they are accountable to other agencies such as policy communities, healthcare institutions, professional bodies and the general public (Goodyear-Smith & Buetow, 2001). Similarly, mental health service users might want to accept the encouragement and support that workers offer in promoting their wellness, but they could experience this 'assertive outreach' as an intrusion which erodes their autonomy and takes their control away (Krupa, et al., 2005).

Ethnographic approaches are used to make sense of these diverse stakes and accountabilities. Practitioners are conceptualised as engaging in 'moments of strategic dishonesty' during consultations (Seale, et al., 2006), while claims are also made that it is in the interest of the service user to give false information in these encounters (Dongen, 2002). Accounts of side-effects or the limited effectiveness of medications might not be given by the doctor. At the same time patients might fail to mention risky behaviours such as drug or alcohol use. Also, to maintain their continuing access to welfare benefits, patients must demonstrate the severity of their illness. So they

might withhold information on their ability to manage their symptoms or the degree of their successful functioning. The person who suffers severe and enduring mental health problems can be understood from an ethnographic perspective to have ‘chosen an alternative life-style’ (Dongen, 2003).

Summary

When people visit their GP and decisions are made concerning the prescribing of antidepressants, complex difficulties can arise in the understanding of rights and responsibilities. It is not clear whether these parties can or should meet as equals and a paternalistic ‘doctor knows best’ attitude is often adopted. The experience of depression arises in a social context and practitioners also make decisions in line with professional guidelines in complex healthcare networks of governance and accountability. Dilemmas often arise where people find they can cope while taking antidepressants, but must then decide whether to continue with this treatment. They must consider what this means in terms of personal volition and there is an expectation that they should find a more authentic response to the difficult emotions other people cause them to feel.

Psychotherapeutic interventions promote rational thinking so that unwanted feelings can be managed. But this section has reviewed literature in which it is suggested that people can be thought of as failing to adopt a self-actualising approach to their lives if they damp down their emotions by taking medication. It is commonly thought that the ability to exercise control over one’s actions can be undermined by a mental health problem. If a person is thought of as unable to take responsibility, uncomfortable enmeshed relationships develop and workers are held to be accountable for ensuring

that illness is treated, that risks are avoided. Where this kind of interdependence develops, dishonesty and conflict are a likely outcome.

Conducting research is difficult where participants might not be honest due to their conflicting interests. However, the use of a phenomenological attitude should help in opening up the experiences of participants in this study. The study is intended, for example, to reveal the experiences of workers as they try to involve the people they are helping in decision-making processes. Research is also difficult in this area where questions arise as to whether people are able to understand the nature of the decisions they face and these questions are explored in the next section. A phenomenological approach is more able to overcome these difficulties, in a respectful and careful exploration of each person's experiences.

Mental capacity to make decisions

When approaching a complex topic it is important to attend to the stories people tell about their experiences and to understand the manner in which they are making sense of their lives, along with the choices they make. A hermeneutic phenomenological approach incorporates a close examination of narratives. This enables an understanding to develop which does not adopt interpretations uncritically. In contrast Government policy is not often built on this kind of careful listening or understanding. For example, many assumptions are imposed on mental health workers by the Mental Capacity Act 2005 along with the associated professional guidance that they are obliged to follow.

This section begins by examining some assumptions which bureaucratic and legal assessments of ‘mental capacity’ promote. This includes the idea that if people are not suffering from mental health problems then they will make rational choices in which they move towards their intended goals. Because of this, it is found that if mental health services can find a logical process driving a person’s choices then this can be used as a reason to withhold support; they are not incapacitated enough to qualify for help. Also, if a person is thought of as making ‘unwise’ decisions knowingly, they can be held to account for the consequences of their choices. Support or treatment would not be extended to them.

Phenomenological research is discussed where decision-making is viewed as complex and notions of intent, calculation or self-interest are often read back into situations. Researchers have observed an increasing requirement that states of ‘mental capacity’ are assessed and recorded. This has been a requirement in other healthcare settings where people receive intrusive treatments for physical health conditions. In these contexts, uncertainties often develop around a person’s ability to understand the need for treatment, or to comprehend the consequences of accepting or refusing it. In legal processes it is a matter of concern that a person might not be making an ‘informed choice:’ that they do not know what they are agreeing to. However difficult existential dilemmas are noted where it is not clear that anyone usually make choices that are ‘informed’ in this prescribed manner

Mental capacity

The Mental Capacity Act 2005 requires that, if possible, mental health practitioners should always enable a person to make their own decisions. But if this is not possible,

they must make decisions in their ‘best interests.’ This kind of ‘surrogate decision-making’ imports notions from legal and philosophical debates and is employed in mental healthcare for two different groups (Owen, et al., 2009). It is employed firstly for those who suffer from conditions such as dementia or learning difficulties, because they lack the cognitive ability to retain information or calculate pros and cons. Then secondly, for those who suffer from conditions such as psychosis, depression or anorexia nervosa, because they might be too distressed, deluded or paranoid to retain information and act on it effectively. People who fall within the first group are thought to experience a permanent or an increasing form of incapacity, while the difficulties experienced by those in the second group can be transient.

Within traditional approaches, as described above, assessments are used to ‘make sense of someone,’ assuming that there is a psychological or psychiatric problem which requires expert analysis. This is however turned on its head by developing interpretations of mental capacity, so that workers must now always start with the assumption that the person has a ‘capacity to make rational decisions:’ an assumption which stands unless they can find evidence that an illness process is causing them to make irrational choices (Department of Constitutional Affairs, 2007). However this understanding imposes various kinds of dualism, in which the mind is seen as separate from the body, just as the person is separate from their illness; or acting as an independent agent, separate from family or community. It is then required that particular principles are followed in mental health practice. It is required, for example, that people must not be excluded from decision-making processes while they have capacity to contribute. Similarly, their right to make an ‘unwise decision’ must be

protected; as long as they understand why making that irrational choice is not in their best interests.

The kinds of dualism described in the current study are expressed when it is either the person's own 'psychological self' which weighs up the future benefits and burdens of a particular course of action, or the team of workers who 'act in their interests.' In contrast to this it is observed in phenomenological and ethnographic research that each person will understand their situation in an idiosyncratic manner and will speak about their symptoms and decisions in the language of their own lay narratives (Engelhardt, 2001). The body through its suffering requires that the person makes sense of, or gives meaning to their experience at a very personal level (Kirmayer, 1992). But the systematic removal of this 'embodied social self' can be very easy in mental healthcare, where a person's ideas can be heard as delusional beliefs. If it is necessary in the calculation of best interests, any idiosyncratic ideas and related forms of subjective experience can be interpreted as no more than symptoms of the illness (Doyal & Sheather, 2005). Symptoms of illness and irrational thinking are again viewed as hindering pre-existent and always rational decision-making processes.

Encountering 'Catch 22'

The principles promoted by the Mental Capacity Act 2005 appear to empower and protect liberty, but at the same time a limit is also set on the state's responsibility for meeting the needs of people who are struggling in society. This means again that the ideology of empowerment can be viewed as Neoliberal, in the sense that it enables the state to claw back support and resources, while also claiming that it is protecting freedoms (Baistow, 1995). For example, when resources are limited, workers might

actively define people as eccentric rather than mentally ill. This would be a claim that they are knowingly making irrational decisions, rather than suffering incapacity and there will then be no obligation to meet their needs (Griffiths, 2001). This creates a kind of 'Catch 22' (Heller, 1962), in which people who are sufficiently aware of their needs so as to seek help, are not considered sufficiently incapacitated so as to qualify for that help. If there is some way in which the person can be understood, or 'made sense of,' as acting in their own interests, then rational grounds are found for their behaviour.

As the principles of the Mental Capacity Act 2005 are applied in mental health practice, the Government in England and Wales also invests in Cognitive Behavioural Therapy. This is a means of helping people develop attitudes and coping strategies which it is thought will enable them to adapt to ongoing health problems (Salmon & Hall, 2003). When people seek help from underfunded services they are unlikely to gain emotional support, therapy or practical help. They are more likely to receive 'self-help literature,' in which they are advised to make decisions in a more rational manner. This understanding of mental activity as a form of information processing is promoted in cognitive psychology and the measurement of these processes is commonly framed as a positivist scientific approach. The operationalisation of competence in terms of the value-free category of 'rational decision-making ability' can help practitioners to maintain a sense of objectivity in their assessments, but this bias towards cognitive functioning fails to consider many other aspects of experience (Breden & Vollmann, 2004).

Practitioners might place more emphasis on cognitive processing because they need not then consider messy interpersonal phenomena such as emotions or social context; a challenging emotional disposition can be singled out as irrational and unwanted. This means that therapeutic interventions can then be framed as ‘rationality enhancing techniques’, such as promoting ‘reality-testing’, so that ‘automatic thoughts’ are challenged and ‘unexplored assumptions’ are corrected (Padesky & Greenberger, 1995). Measurements can be made of a person’s ability to retain information along with their ability to calculate the pros and cons of different options. Then, when it can be shown that the person is able to comprehend decision-making in these terms, they can be held to account for the choices they make as individual rational deciders.

Hearing the story

When employing a hermeneutic or narrative based form of phenomenological enquiry, healthcare interventions are seen as a context-bound moral practice, which can never be value free (Benaroyo & Widdershoven, 2004). Competence to make decisions is not about the ability to retain and evaluate abstract concepts. It is related to a person’s practical and habitual interactions with people and things; their embodiment in a life context. People can appear incompetent when they are unfamiliar with life situations even when they are confident and capable in many other contexts. Within this perspective, decision-making is about the meaning, or lack of meaning, that these situations have for the person; it is not solely based on an intra-psychic capacity for reasoning. So when people are accustomed to having their needs met, because they are treated as if they are incapable, they will struggle to enact choice; although they can perhaps comprehend the notion at a cognitive level and describe the rational terms on which choices are made. People who have become

‘dependant,’ feel that their relationships with mental health workers provide them with ‘security, validation and companionship’ (Horberg, et al., 2004). But the notion of empowerment requires that they must find other means of meeting these needs. Workers might therefore decide that support must be withdrawn, so that dependent people must learn how to function in society in the same manner as everyone else.

Housing policy provides an example of how an emphasis on cognitive process and rationality can impose moral judgements and enable a shifting of responsibilities. If someone is understood to have failed to abide by a tenancy agreement, for example, due to the effects of a mental illness, then the Local Council will still have a duty to house them. However, if they have broken their agreement wilfully or because they choose to misuse alcohol or illicit substances, then they can be judged to be accountable for their actions. Housing applicants who make irrational or ‘unwise’ decisions can be treated as ‘intentionally homeless’ or otherwise blamed for their problems and denied support and the assessment of mental capacity can be a means by which the bureaucratic processing of a housing application is enabled; a process in which the person might be defined as a member of the ‘deserving or the undeserving poor’ (Clapman, 2007).

Decisions which might otherwise seem irrational can make sense when values, emotions and other biographic and context specific issues are taken into consideration (Dongen, 2003; Laing, 1969; Watts & Priebe, 2002). Although practitioners will, perhaps, feel impotent when they get bogged down in these difficult processes of inter-subjectivity and emotionality, many people who seek help do not ‘act in their own best interests.’ They engage in self-destructive behaviours such as self-harm,

para-suicide or self-neglect. These are perhaps authentic emotional responses to experiences of abuse in complex social relationships, in an impoverished and interdependent life-world. However these authentic feelings might only hinder workers in their attempts to impose rational institutional processes. Where resources are stretched, workers do not have time to effectively engage or understand the person they are trying to help. So if workers do consider the patient's subjective values, beliefs, emotions, culture or past decisions, it is thought that this is unlikely to be formulated into anything more than a homogenised stereotype of the 'problem patient,' who disrupts the smooth running of the healthcare system (Dunn, et al., 2007).

The promotion of an individualist and self-promoting understanding of decision-making can make the notion of 'caring' a contentious issue in mental healthcare. Professional care can be understood as healthy because it is remote and impartial. While assumed self-interest causes us to wonder what someone gains by caring in informal social contexts. Different expectations of how these forms of care should be expressed can lead to conflict. For example a parent who participated in a research study is reported to have said; "*When I show that I care I'm met with hostility. 'Why do you care'? and that has disappointed me. Cause then I think that no one cares. Are we not supposed to care today?*" (Jakobsen & Severinsson, 2006: 500). Informal caring might be seen as part of the problem, as an 'over involvement,' as taking over to meet one's own emotional needs. One person's experience of caring and the other person's feeling of being 'cared for,' might not correspond in relationships and disputes over just who cares and how much will occur, bringing strong emotions to the fore (Wilkinson & McAndrew, 2008).

From a phenomenological perspective, notions such as volition, caring and free-will are not pre-defined or easy to describe. They are rather, very personal experiences and this stands in contrast with cognitive psychology, where these phenomena are seen as self-evident and universal phenomena (Hurlburt, 1992). The observational methods of psychiatry also attempt to define signs and symptoms of mental illness as independent of the person who happens to be suffering (Aho, 2008). It is found that in brief outpatient reviews, practitioners struggle to develop empathy, often ignoring and talking over the concerns of the patient. The patient's attempts to be included in the decision-making process can be interpreted as awkwardness, or signs of mental illness (McCabe, et al., 2002). In contrast, when workers do have the time to engage with service users they report that they are able to take the step of "*discarding their walls of professionalism to reveal a desire to know the client as a person,*" by "*showing a more human side of myself,*" in order to "*embody themselves in the client's world.*" (Addis & Gamble, 2004: 456).

Summary

Researchers should listen to the stories people tell and understand the manner in which they make sense of decision-making processes in mental healthcare. This enables us to see that many assumptions are expressed in policy and practice. It is assumed that people are already a rational decider and before professional intervention is justified, evidence must be found that they are incapacitated by symptoms or psychological problems. These assumptions are expressed in Government policy related to the notion of mental capacity and in Local Authority responsibilities to provide housing. If mental health services can find a rational

process driving a person's choices then this can be used as a reason to deny or withdraw support.

Phenomenological studies suggest that people make decision most often in a habitual, interpersonal and emotionally connected manner. Notions of intent, calculation or self-interest are often read back into situations. A phenomenological attitude can observe how these meanings are brought about but then set them aside to ask how participants experience these processes. Meanwhile, the use of narrow forms of analysis, which are only based on cognitive psychology theory, might lead to simplistic judgments, reframing decision-making as an expression of calculated self-interest. This might be connected with the increasing promotion of commercial and economic means of organising our lives. The next section picks up on this possibility.

Consumerism and democracy

The introduction of organisational structures from commercial enterprise can be seen as another change in policy within which an understanding of people as individual rational deciders is promoted. With the closure of Victorian asylums in the UK, community teams were set up to meet needs, although concerns were expressed about the ability of these teams to respond to multiple and conflicting demands. Literature is considered in this section where it is observed that the notion of democratic decision-making is promoted in these teams but workers continue to exercise authority within various professional roles. This means that participants in decision-making usually have different degrees of professional status and the people who are seeking help are understood to be made vulnerable by mental health problems. Equity in mutual decision-making is therefore difficult to achieve.

The difficulty of agreeing a mutually agreed understanding of why people are seeking help and what should be done about this is now complicated by commissioning arrangements in which therapies and interventions are listed in a kind of menu, so that they are provided in a financially managed and time limited manner. Literature is reviewed in which these constraints are found to cause complex rhetorical disputes. It might be claimed that people who seek help are unwilling to accept responsibility for their own lives and that workers are willing to foster dependence in continuing to work with them. In contrast, it might be argued that workers are uncaring and neglectful when they try to move people on and discharge them from services. When these understandings are promoted the shortage of adequate support is not then recognised as a failure in the system of care. The understanding of an individual rational decider who can be held to account is brought to the fore. Once more, it is a phenomenological approach which attends to the experiences of these individuals, which can help unpick complex disputes and provide a more balanced and compassionate form of understanding.

Failing democracy

The ideological conflicts in mental healthcare, summarised above, are perhaps further complicated by the introduction of principles and organisational systems adopted from the sphere of commercial enterprise. Healthcare services had changed in the UK across the twentieth century, from local community resources, which were funded through subscription, to a nationalised system funded through central taxation and then more recently, successive Governments have tried to privatise aspects of these systems. The idea is promoted that patients are customers or consumers, while it is

argued that the role of citizen is perhaps a more helpful label (Barnes & Shardlow, 1997). Citizenship can be understood as connected with group based democratic decision-making. However, with an increased emphasis on consumerism and individualism, a collective means of making choices is rarely available.

As patients were decanted from the large Victorian asylums and community teams set up, concerns were initially expressed that unmanaged demand and complex decision-making-processes would evoke difficult emotional responses, such as impotent anger. It was thought that these teams might dissolve into chaos or professional splits, with a culture of blame leading to defensive practice, where workers pay undue attention to bureaucratic requirements (Galvin & McCarthy, 1994; Foster, 1998). However with the development of the 'Care Coordinator' role in the UK, most workers were made to account as individuals to a Team Manager rather than to the collectivism of their professional body. It was hoped that democratic decision-making processes would then lead to a more effective use of resources (Onyett & Ford, 1996).

The notion of democracy which places emphasis on everyone contributing to decisions and on citizen rights, can present practitioners with difficult dilemmas. They cannot just offer choices but must also provide expert opinion, so that the people they help can exercise 'informed choice' (Billig, et al., 1988). Also, although team based decisions might appear more democratic, decision-making is likely to be influenced by differences in status between professional groups; a case of 'we decide and you carry it out' (Cott, 1997). This inequality is again influenced by different theoretical understandings. It is observed that broadly incompatible understandings of mental illness are expressed by different professional groups. These understandings operate

at those social, psychological and biological levels while also standing in sharp contrast to the thinking of people who use services. Very different rights and responsibilities are expected (Colombo, et al., 2002; Donnison, et al., 2009).

Professional opinions can have a powerful influence and those dualist understandings of a separate mind and body can be imposed, or a separation constructed between the person and the social context in which they find themselves. In these interpretations the patient is often divided into different components, corresponding to the conflicting knowledge frameworks of doctors, psychologists and social workers. Where someone is understood in different ways they might, for example, be thought of as retaining a healthy mind while their body is diseased and this separation can then be extended through the elaboration of the disease entity, which is attributed with a kind of agency. Someone might say that their depression is preventing them from attending for work, rather than saying that they are struggling to find a more stimulating form of employment. The management of this entity is then understood to be the responsibility of their doctor. The decision to attend for work or not is, therefore, as much about the manner in which agency and illness are understood as any intrinsic quality of the individual.

Managed care

With the development of team based decision-making, the question of just who should receive treatment or support - what kind and for how long - is increasingly made through systemised assessments and procedures, in which research evidence is utilised. As priorities are set, resources are targeted at people who are given a specific diagnosis and workers are only paid to deliver effective, 'Evidence Based

Interventions’ (Hall & Callaghan, 2008). In these systems, ‘care pathways’ are designed with the idea that interventions should have defined and measurable outcomes (Hall & Howard, 2006; Scheid, 2003). So where services are commissioned as a closely defined system, in which the nature and the amount of professional interventions are pre-determined for specified diagnoses, this is often referred to as ‘Managed Care.’ This kind of decision-making framework represents a response to the wider institutional demand for technical rationality and efficiency (Speed, 2007). But in this commercialised care, practitioners can only provide constrained forms of support and treatment, which are delivered by them, but within which there is no flexibility or adaptation to individual need (Scheid, 2000).

In a Managed Care system, people who seek help are understood as customers who compete to gain the best deal for them. They are seen as capable and informed, so that they will arrive at consultations having surfed the net, expressing knowledge of available treatments (Strong & Sutherland, 2007). This kind of consumerism can be seen therefore as offering up certain preferred identities, expressed in idealised notions of ‘caring and enabling workers’ and ‘informed or compliant patients.’ However, reaching agreement is difficult when resources are limited; where practitioners do not have adequate time to engage in protracted and mutual decision-making negotiations. Healthcare organisations will then struggle to position themselves as delivering outcomes (Galvin & McCarthy, 1994). Perhaps in response to this, there has been a constant process of change in the UK, as organisations and services are set up, reviewed and disbanded. Institutional rationalism can be understood as a response to this apparent disorganisation.

The introduction of market principles brings new ethical dilemmas to the fore in healthcare. There is an expectation that people's needs should be met in a fair and equitable manner, while in contrast, it is everyone's priority in a market place to maximise their own gains. So workers can feel that their loyalties are split. How do they balance their duty to maintain the financial viability of their organisation against their duty to provide for the needs of their service users? Practitioners will be aware that where there are pressures to meet strict financial targets, they can easily be positioned as 'over emotionally involved with the people they are trying to help.' So a need to appear rational might pull them into line with financial management plans. Concepts such as 'depersonalisation' and 'emotional fatigue' are utilised, as a means of describing or measuring the distress which practitioners can experience in these difficult working conditions. Mental health practitioners are found to report such problems more often than workers employed in other fields (Onyett, et al., 1997). Where institutional processes are enforced through a managed care system, workers are likely to lose their autonomy, their ability to be creative along with their opportunity to find variety in their work; but these are all found to be factors which protect against depersonalisation and emotional fatigue (Dallender & Nolan, 2002; Onyett, 2011; Ward & Cowman, 2007).

Workers would not want to be seen as 'emotionally burnt out' while patients who are cast as ethical consumer might also experience discomfort and anxiety, as they must not trouble their workers unnecessarily and they must 'choose' to follow the burgeoning raft of health promotion advice that has been targeted at them (McDonald, et al., 2007). Decisions in this context are therefore mediated by the interests of participants who seek to hold onto positive positions in disputes. Rhetorical strategies

often involve the positioning of self or others so as to gain status or exercise power. Workers and the people they are trying to help might feel they should appear as rational, rather than emotional. Disputes of this kind are very complex but generally, it is likely that ‘neglectful or over-involved workers’ and ‘ungrateful or over-dependent patients’ will lose their negotiating positions in everyday conflicts.

As commercial agendas are set up in healthcare systems, doubts arise as to whether practitioners will, or can, actually act in the interests of patients. Perhaps, following the principles of a marketplace, they can only work to maximise their own gains, in competition with others. So in this developing economy, patient choice and expertise are ‘commodities’ which will be valued in the regulation of services (see ‘patient choice’ in; Department of Health (2007), for example). People who use mental health services are now asked to contribute to developing and evaluating those services; they are paid for their contributions as ‘experts by experience.’ However, the notion of the ‘health care consumer’ is only meaningful when the person seeking help can act in a rational and self seeking manner with access to information on available services. It is only meaningful if there are different services from which to choose. Choice is not likely to be meaningful if the only service available is predetermined and closely defined. Also, this is a setting where people are distressed, distracted and detained against their wishes under mental health law. Interpreting their position as that of a consumer does not grant them power or choice. While at the same time, it does not grant workers the power to offer more options (Speed, 2007).

Summary

Democratic decision-making is difficult to achieve in mental healthcare, there is a call for rationing of resources and principles from commercial enterprise are imposed instead. Professional workers hold different degrees of status and, given this inequality, it does not seem likely that the person seeking help will be included. Without a unified and mutually agreed means of working, mental healthcare can appear chaotic and this is not helped by constant organisational change. The introduction of market principles and Managed Care seems to be a means of bringing order, but the autonomy of individuals within these systems is more limited and the current study is set up so as to explore these processes. Constraints on involvement can then be understood as connected with various disputes in which people are attributed with negative qualities and generally blamed for failures in the system of care. Once more, a phenomenological approach which attends to lived experience can help unpick complex disputes and provide a more balanced and compassionate form of understanding.

Conclusion

Mental healthcare is a setting which is fraught with conflict as different interpretations are promoted or imposed. These are based on theoretical modelling which often falls within separate spheres of sociology, psychology or biology. Reductive causal models are often taken up in popular understandings as people debate with each other in making sense of behaviour. It is commonly expected that people should be able to choose their own direction in life and when they are unable to do so conflicting explanations are expressed. When a person is distressed, disagreements might arise as to whether they need to be removed from society so that their behaviour is contained,

or if they are removed, it might be claimed that it is this denial of their liberty which is causing distress. It might be thought that a failure to feel happy in response to a distressing or unfulfilling life should be corrected by a change in attitudes, a kind of psychological adaption, or by the chemical control of emotion. However this pressure to change one's self so as to tolerate a distressing life-world might be thought of again as an imposed regulation, a denial of our right to self-expression.

In the calculation of mental capacity, emotional and social problems are set aside and workers can appear to act independently of the moral choices each person faces, or the degree of poverty, social exclusion or deprivation which they might suffer. An imperative is created and imposed on us as individuals, in which our decisions must make sense; while our irrationality and over emotionality lurk in the background, requiring that we are constantly vigilant. This way of being is supported by ideas that are promoted through notions of empowerment and recovery philosophy. This ideology is Neoliberal in the sense that it shifts responsibilities for meeting needs from the state to individual citizens.

It is increasingly expected that care and treatment are delivered within a market economy in which costs are driven down by competition and it might be thought that consumerism will increase freedom of choice. This means that social encounters in mental healthcare are now more likely to be framed as 'transactions', which are recorded in a care plan, signed by both parties. The assumed 'small print' in these contractual arrangements requires that people are seen as rational self-seeking actors. Psychotherapy is not emphasising the freedom people experience in making choices but driving them towards narrow rationality and pushing them into conforming to

socially valued roles. Emotional wellbeing might be set aside in an over-valuing of individual choice, which does not fit with ordinary everyday decision-making processes. In caring for people, mental health practitioners might struggle to support or respect the basic existential need to make sense of experience, the need to feel connected with other people. These changes are not therefore just about economic constraints but, that the meaning of ‘autonomy’ or ‘caring’ or ‘rationally’ can be imposed rather than negotiated (Pippin, 2005). In contrast, a ‘narrative ethics’ approach attends to the manner in which people habitually make decisions, in which stories are used to explain experiences and give them meaning (Higgs, 2004).

This chapter observes the manner in which researchers in mental healthcare usually adopt one or another incompatible form of understanding. It is also found that these ideas are taken up by people as they give their experiences meaning, often in conflict with each other. Researchers then appear to be mixed up in these conflicts, taking one side or the other, imposing different models. Mental healthcare might become more ‘health enhancing,’ if the meaning-making practices of the people who provide and use services were all attended to (Willette, 1998). It is important therefore that the current study hears and describes the actual experience of people who find themselves caught up in the processes of mental healthcare. It is important that this study observes the meanings expressed in this context and attempts to make sense of this in the light of the changing ideological interpretations at play in this setting. The study might then be able to inform policy and practice.

Research questions:

The following questions are based on those which were proposed in the original study proposal. These questions were refined through the processes of gathering and analysing data.

1. How do people who use mental health services experience an involvement in making decisions about their care and treatment? Do they associate this with a greater sense of personal agency? What do their informal carers say about this?
2. What meanings do mental health workers give to the involvement of their service users in decisions about their care and treatment, or about the design and delivery of services in general?
3. If there are different understandings of involvement in decision-making, what does this mean for policy and practice development?
4. How are principles from phenomenological theory and critical analysis able to inform our understanding of decision-making processes in mental healthcare?

Chapter 3: Methodology

Introduction

I have argued that the topic of decision-making in mental healthcare needs to be approached with a phenomenological attitude and a focus on lived experience. Existing research in this area does not adequately address the manner in which understandings are commonly disputed. Most studies explore lived experience as it is described by participants who are already categorised as particular kinds of person. It is assumed, for example, that when people suffer from depression, are employed as mental health nurses or are a family care giver, then they will have a stable disposition. In the current study, however, I am approaching these phenomena as narrative identities that are taken up and set down by people in particular social contexts. Participants might, at one time or another, be placed in any of these categories; even though these ways of being have biological and psychological foundations. Following Paul Ricoeur (1992), I recognise that narrative selves are multiple and contingent. I do not assume that experiences or actions make sense in the light of just one narrative identity. The meanings of experiences and actions are contested as people take up these positions, avoid them, or place others within them.

We have seen that, where research is conducted using other methodologies, processes are proposed which act at biological, psychological, social or political levels. These understandings are then taken up in complex conflicts in which participants might propose that decisions are influenced by one or more of these factors and then disagree over who holds rights and responsibilities as a consequence. I have suggested that particular understandings of what it means to make choices are often imposed

where decision-making is viewed as an individual rational means of advancing one's interests and moving towards personal goals.

In this chapter, I will describe the study, starting with an account of the methodological approaches that I have adopted. This leads into an account of the specific research methods, describing the participants, the interview approach, the analysis of data, the use of reflexivity and the research design. Ethical concerns are then addressed and I end the chapter with a summary of the research protocol.

The Methodological Approach

Description is an essential tool in the methodology that I employed in the study. I have worked to draw out aspects of experience while processing every detail with an equal attempt to find meaning. This search for meaning has not reduced material to simple principles or models and no structures or hierarchies were imposed. Conflicts and contradictory understandings were allowed to stand and I did not need to consider whether one point of view was more truthful or correct than another. I did not assume that the words participants used must always refer to a consistent or a 'real' world. I found truthfulness instead, more often in the emotional content of the language that was used.

I did not expect that experiences could be simply categorised or that people would express themselves within stable narrative identities, where they have just one way of making their lives meaningful. I found that experiences were complex and embedded in particular times and places, where they were given conflicting interpretations. I took time, therefore, to work on the data, to weigh and to process meanings and

emotions. I was then able to draw out something that was essential to the experience of each participant; something that was particular to their life setting, but opened up for us all to understand.

The things themselves

I conducted the study within a tradition of phenomenological enquiry that is grounded in Edmund Husserl's original call for researchers to 'turn back to the things themselves.' Husserl developed an analytical approach within which the researcher tries to stay as close as possible to our human experience of the phenomena under investigation. Husserl sought a direct access to truth in which a more accurate understanding might be generated when pre-existing or assumed forms of modelling are set aside. He observed that people are routinely unthinking as they express a 'natural attitude' and we need to move beyond this if we are to develop our understanding of the object of our study. However, rather than attending only to the object, or only examining the understanding of the observer, it is important to explore the experience. In Husserl's approaches this experiencing is central.

Experience can be shared but unlike the approaches of the natural sciences, phenomenological researchers do not usually attempt to say something which could have a universal application, in which general laws or principles can be stated. I have not assumed in the study, that our understanding of decision-making processes can be reduced to a model which is separate from the specific and local experiences, activities or meanings that were observed through the research process.

In an attempt to capture the total experience of participants in as much detail as possible, I have followed Husserl's technique of description, through repeated reflection on the phenomena. This enabled an exploration of understandings beyond immediate consciousness and my awareness grew as I tried to set aside preconceived ideas. In developing this awareness, I held to a principle of horizontalisation by rejecting models or theories which would place some aspects of the phenomena as more pronounced or significant than others. Having developed my understanding of that which is essential to the phenomena I have employed a process of verification by going back again, repeatedly, to check my understanding against the phenomena.

Situated being

Husserl's student, Martin Heidegger (1962), developed a philosophy of situated being. Husserl had taken up the intentional quality of consciousness as always confronting something other than itself and Heidegger elaborated this sense of the 'there' of being. This is a recognition that we live in a certain time and place in a manner which is already made meaningful. In employing this way of thinking I could not map pre-prepared theoretical models of decision-making against the research data. This is because the meaning of the phenomenon is not mine to work back into situations. It is already there in the experiences of those who are involved in it.

I have taken note that Jean-Paul Sartre wrote about the quality of this situated existence in which we face an unavoidable openness in our choices. While we are 'condemned to be free,' I have also recognised that this freedom is always within limits, within the facticity of existence (Sartre, 1969). Again, I cannot simply adopt an understanding of personhood and expect that this will match against the experiences

of participants. Unlike humanism, phenomenological enquire does not place personal agency centre-stage, as if people can make any choices they wish as separate rational actors. Husserl had observed that people are brought into existence through an engagement with the meanings and options which are available to them in the present moment, always in an embodied state and always in relation to other people in a cultural and historic setting. These aspects of being were elaborated by Maurice Merleau-Ponty (1962) who observed how experience is also mediated by shared understandings. I was open, therefore, to the possibility that I would encounter processes through which participants are brought into being, through the decisions they make, in a complex encounter with the meanings applied to their particular form of existence.

Heidegger spoke of a pre-reflective experience of the world which entails anguish, fear or guilt and this is explored by Sartre and Merleau-Ponty. Sartre emphasised the emptiness of existence, where there are no essential qualities to human nature, with no direct connection to a personal history, emphasising openness and freedom. I did not expect, therefore, that I would be able to predict the choices a person might make, because the nature of their being would not be reliably stable. The nature of that being is just as much an outcome of the choices they make, as a predetermining factor in the formation of those choices.

Merleau-Ponty turned towards the imperative inherent in our existence; that we must give meaning to our experiences. For Merleau-Ponty, freedom is not the basis of existence, we experience ourselves instead in the way in which we act and take up positions in the world. The need to account for the body is recognised, while

consciousness is understood as always embedded in the world. Self-knowledge is then viewed, therefore, as only ever being possible through a shared encounter, a being-with-others, and an involvement in human affairs which are already invested with contested meanings. I found myself caught up in these affairs through my research approach and I found reflexivity to be a necessary tool in my own attempt to draw out a consistent sense of myself and the understandings I developed.

Although the analysis I provide is mediated by my own being, the call to ‘return to the things themselves’ is still heard, as I attempt the technique of ‘epoche.’ I tried to abstain from presuppositions or preconceived ideas, sometimes referred to as bracketing; although Merleau-Ponty observed that the embedded nature of consciousness raises the question as to whether it is ultimately possible to transcend current experience. However, by holding with Husserl’s original thought, I have engaged in the practice of examining experience first, before asking ‘who perceives these things?’

A hermeneutic analysis

The hermeneutic analysis that I have conducted also follows principles set out by Hans-Georg Gadamer and Paul Ricoeur. Description leads to interpretation, because, as Ricoeur observes (Langdridge, 2007), the words which participants and I spoke to each other were fixed in the moment, a moment that ended. My subsequent description of these words frees them from that moment, opening the world to which they refer, so that it can be interpreted and made accessible to those who read my account.

In my appropriation of meaning there is process of returning time and again to the narrative material I gathered. There is a creative engagement in which I explore meanings asking questions about how things might be understood from different points of view and what would happen if different aspects of the situation were described differently. My concern was to uncover that which is essential to the experiences described; something without which the phenomena could not be what it is.

Having gained a sense of living in the world that participants described, I condensed this into an analysis which the reader can experience. Ideally, the reader's experience should involve only that sense of living in the world of the participant, an experience which should be communicated in a manner which is as free as possible of my own experiences as the researcher. To achieve this separation, of that which was so completely enmeshed, I stepped back from the encounter recorded in the interview transcript and related notes. I worked again to suspend my presuppositions as I entered the life-world of participants. I then practiced the epoche so as to remain there laying open the phenomena which are of interest (Ashworth, 1996). The life-world is understood directly in these processes, not through the mental constructs of participants, or through an account of their social setting, as there should be no separation of inner and outer life.

In my analysis I was not trying to say something about the particular qualities of a group of people, as in a psychological analysis of this or that 'personality type.' At the same time the biographical details of specific individuals would not be my main area of interest. I tried to present a shared experience so that the reader might say; "Yes;

that is how I would feel, behave or express myself, if I had that experience.” However, the transient and unpredictability of that experience must also be recognised. Max Van Manen (2006) describes:

“...a shift away from understanding meaning in terms of the relation between name and reference, perceived objects and mental objects, and a move toward the changing contexts of meaning in which human beings find themselves, and to the complexity and instability of textual meaning, the language games and narrative practices that give expression and interpretation to human experience.” (Van Manen, 2006: 714)

To achieve this shift, the analyses I set out in the following chapters are an attempt to realise the emotive and the meaningful; as suggested by Heidegger in his interest in poetry (Heidegger, 1971), along with Gadamer’s writings on beauty (Gadamer, 1986). I returned repeatedly to my writings, reworking them in an encounter with the meanings and the feelings they evoke (Van Manen, (2002). I have chosen words for the emotions they stir up, rather than any assumed designated meaning (Trodres & Galvin, 2008). This is done in an attempt to connect with the experiences which participants express, to get to the essence or the core of this.

Methods

Max Van Manen describes the key steps for engaging with phenomena:

- (1) turning to a phenomenon which seriously interests us and commits us to the world;
- (2) investigating experience as we live it rather than as we conceptualize it;
- (3) reflecting on the essential themes which characterize the phenomenon;

- (4) describing the phenomenon through the art of writing;
- (5) maintaining strong and orientated social psychology relation to the phenomenon;
- (6) balancing the research context by considering part and whole.

(Van Manen, 1990: 30).

In taking these steps I ask; what is at the core of decision-making, in the experience of people who are caught up in the processes and meanings of mental healthcare? What is the essence of this without which the phenomenon could not be what it is? I answer this by spending time and effort in a delicate entering and opening up of the world of each participant. Bringing their world into awareness involved a difficult emotional and reflexive process, in which I ensured accuracy only by a precise and rigorous examination of the narrative material (Langdridge & Hagger-Johnson, 2013). I conducted this examination through the understanding that we are primarily social beings. We are not limited to living within our own experience. Our ability to live with others depends on an interconnection, a pre-understanding in which the meaning of their experience is known, second by second, in a complex mutuality or conversational flow, alongside the manner in which we know our own experience. If we encountered each other in this manner, our conversation or other interaction will take us somewhere which neither of us would, or could, go on our own. At times in this journey we step in their shoes and they step in ours.

My phenomenological enquiry depends on an ability to reconstruct my experience of the experience of the other, as I think through the close detail of our interactions. The methods I employed, therefore, required that I turn my gaze back on myself in a form

of reflexivity which enables the other, in the form of the research participant, to be known.

Re-encountering the social self

As explained with the philosophical work of Maurice Merleau-Ponty, we are 'social selves' first, and then we become aware of our individual self, only through our awareness of others being aware of us (Stevens, 1996). It is this individual self which we have then become aware of that is most often the central topic in psychological research. In bringing that individual self to the fore, the primary experience of a social self is lost to us. In modern societies we most often think about, and examine the nature of, the individual person in an illusion of separation, as a psychological self. But the experience of social selves can also be brought into awareness, as discussed within existential theory (Macquarrie, 1973). We can focus on our awareness of the awareness of the other. This then enables us to see aspects of our self other than that which is thought of as our own individual self, and this is central to the methods employed here.

As a researcher who is engaged in phenomenological enquiry, I became aware of something which I already know; that was my own primary experience of the other. The nature of the other was hidden in plain sight and by a close examination of my encounter with this other I could piece an understanding of them together. However, I did not assume that either myself or the other were pre-existing, but that we were something which might be experienced, or enabled, by the process of encountering each other (Gadamer, 1975). In these processes I employed reflexivity. This involved a process in which my gaze was turned back upon myself, on my own encounter with

existence, for the purpose of allowing the other to be known (Gadamer, 1975). Gadamer also observed that this form of enquiry is not about establishing an individual psychological self, neither my own nor that of the participant. But in contrast, it is an exploration of the specific context and cultural setting that permit the self to be, as myself or as the participant. This is linked with that idea of shared experience; the understanding that I could be like the others I encounter and that they could be like me, if not for our different positions within these particular circumstances.

Within the phenomenological approach I employed in my study, there is an emphasis on shared, rather than individual meaning. I approach decision-making, therefore, as founded on processes of ‘collective memory’ (Halbwachs, 1992). Remembering involves a retrospective process of cutting moments out from a complex flow and restructuring the past to enable it to make sense within an account. Decisions take place within different ‘durations’ (Bergson, 1908 / 1991), within which people are held in a shared means of understanding, in the moment (Carr, 1986). When a participant expressed contradictory ideas, or occupied a paradoxical identity, these theoretical frameworks provide a means by which I could make some sense of their ‘way of being’, by reference to flows and emotional pressures that connect social groups.

Participants

I took care in my study to include a wide variety of participants. This provided access to contrasting experiences of both decision-making and of mental healthcare. Participants also represented experience from different age groups, genders and

cultural backgrounds. However it is not appropriate to assume that a participant falls within a particular category prior to the gathering or analysis of data. I did not therefore collect demographic information in a structured manner. Structured questions might have prompted participants to assume that they should answer questions as a representative of a particular group, not from their own experience. The demographic material which I gained in the interview process is presented in part below with further details related to specific experiences introduced in the analysis chapters. These are therefore aspects of the participants which they felt they needed to share, so as to express their accounts of themselves.

I brought the accounts participants gave together for the purposes of analysis under headings such as; suffering from a mood disorder, mental health workers, informal carers, unqualified workers and suffering from psychosis. However, I did not approach participants as if these experiences formed the entirety of their identity or defined their behaviour. Several participants mentioned experiences which could have enabled them to contribute to different chapters.

Anna was born and raised in England and having attended a state school she trained to work as a nurse; she is White British. In her late twenties she had moved to take on a more senior work role and bought a house nearer to her family. However she struggled with the new job and is now diagnosed as suffering from bi-polar disorder. She lives with her partner.

Ben was born and raised abroad, before being brought back to the UK by his middle-class professional family, where he attended a public school. He is White British and

he endured experiences of psychosis throughout his life with excessive use of illegal substances. He has some work history in skilled labouring jobs. He has mature children but only lived briefly with his partner. He is now in his early sixties. Ben is currently held under mental health law being required to live in a home where nursing staff ensure that he takes psychiatric medications.

Chris is White British. He was born and raised in England, having attended a state school and leaving with good qualifications. He was diagnosed in teenage years as suffering from psychosis. He worked in a variety of unskilled jobs and is now in his late thirties. He was at one time placed in a supported hostel but he now lives in a rented flat and has a number friends with whom he socialises.

Diana is English, from an Asian family and she is in her thirties. She attended state school and gained good qualifications. She lives with her partner and is a qualified Social Worker. She recently took on the role of Team Leader for an Assertive Outreach Team.

Emma is White British. She was born and raised in England, where her family are part of a rural farming community; she is in her late twenties. She attended a state school, leaving with some qualifications. She lives with her partner and mentions a period before she trained as an Occupational Therapist when she suffered from mental health problems.

Frank is White British. He was born and raised in England. He left a state school without qualifications and he worked in many unskilled and semiskilled jobs. As a

young man he also worked for a period as a Nursing Assistant in a psychiatric hospital. He struggled most of his life with alcohol misuse and in more recent years was given a diagnosis of bi-polar disorder. His children are now adults and he lives with his wife.

Greta is White but speaks with an Australian accent and is a Registered Mental Health Nurse. She worked in a number of settings and she is in her forties. It is part of Greta's employed role to make assessments which include judgements about whether mental health problems are adequately treated or not.

Harry is an Asian man who came to England to train and is now employed as a Staff Grade Psychiatrist. He is responsible for prescribing and managing treatment in both inpatient and outpatient settings. He leads decision-making processes on behalf of the Consultant Psychiatrist. He is in his forties.

Ian is White British. He was born and raised in England and attended a state school. He worked in several skilled and semi-skilled jobs, before training as a Registered Mental Health Nurse. He subsequently worked in hospitals and in the community. He is married with young children and is around thirty years old.

John is White British. He was raised in Scotland, leaving school to work in a number of skilled and semi-skilled jobs. When his marriage failed he trained as a counsellor and has been employed for around ten years as a Support Worker attached to an Assertive Outreach Team. He is now in his fifties.

Kevin is White British. He is a Chartered Psychologist who is employed to make assessments and provide therapeutic interventions. He has a clinical leadership role in a Community Mental Health Team. He had previously worked in Therapeutic Communities. He is married and is in his thirties.

Laurie is White British. He gained a good education before starting to develop a professional career. He was then diagnosed as suffering from psychosis in his twenties. He had at one time managed to gain a well paid job and was paying a mortgage on a house. However he lost this job and his home. He more recently gained some work in computer based design and is now in his fifties.

Mira was born and raised in a wealthy family in a Middle-Eastern country. The family moved to the UK due to political persecution and her brother was diagnosed with psychosis, being treated in inpatient services for periods over many years. Mira is trained and is working as a Psycho-Therapist. She is in her fifties.

Naomi is White British. She was born in England and is in her fifties, living with her husband in a rural location. She is employed part-time as a Youth Worker. She has several children including a daughter who was diagnosed with psychosis.

Olivia is White British. She was born in England, attended a public school and worked in a variety of jobs. She is currently employed by the local council as an Ethnic Minority Development Worker. She recently divorced and is in her late forties.

Peter was born and raised in England. He attended a state school, leaving with some qualifications and gaining employment a variety of skilled and semi-skilled, jobs including self-employment and management roles. He then trained as a Registered Mental Health Nurse. He worked in a number of roles in mental healthcare. He lives with his partner and children. Over the past ten years, he was diagnosed as suffering a recurrent depression.

The interview approach

As described by Max van Manen (Van Manen, 1990: 66) the interview serves two very specific purposes in a Hermeneutic Phenomenological approach. I used this approach firstly to gather and explore narrative material related to the experience of participants and this served as a resource for developing a deeper understanding of the human existence under investigation. In this approach our partnership involved distance and difference in which the participant said something, while as the researcher I recorded this, then attempted to make sense of it. Secondly, I used the interview to develop a conversational relationship with each partner and interviewee, in which shared meanings were generated. There was a partnership of similarity in this approach, because it was in our sharing of experiences that joint understandings were constructed.

I recruited participants because of their unique experiences which were of interest in addressing the research topic, but it would be problematic if I conveyed that experience as something that seems remote and extreme. I worked therefore to make sense of these experiences at a general level of shared existence. There was a movement from the mutual construction of meaning in our encounters, to my

description and analysis of the words we used. These words were then freed from the moment in which they were spoken, opening the world to which they refer. It was useful therefore to ask questions which are grounded at that common level of human experience. The questioning processes is informed therefore by existential commonalities; spatiality, embodiment, temporality and relationality (Heidegger, 1962; Merleau-Ponty, 1962; Van Manen, 1990).

In conducting interviews I tried to ensure that participants felt free to speak about their experiences, while not feeling judged or put on the spot. I followed a schedule, reproduced in Appendix 1, in which I told participants that they were free to speak but that prompt questions would be used to help them cover all aspects of the topic. I prepared these prompt questions with my supervision team prior to the interviews. However, I also employed the interviewing skills of immediacy and empathy, so as to help participants feel that they were having a conversation with someone about experiences which are understandable, with a potential to be shared by others.

If I acted as separate and in total control, working to extract expected data from participants, then questions would be raised about whether the material reflected the participants' experiences or just my own pre-reflective understandings, which participants were prompted to confirm. A variation in my style of questioning was required therefore, from a formal request to provide specific information with reminders to stay on the topic, to the use of a degree of self-disclosure, in which I made attempts to set participants at ease, enabling them to reflect and speak freely. I sought answers to questions which reveal experience in a full engagement with thinking and feelings in an embodied state, at particular times and in relation to other

people. I asked, therefore, ‘where and when was a decision made,’ ‘who was involved,’ ‘how did the process feel,’ ‘what happened’ and ‘what did this mean for the participant?’

The analysis of transcribed interviews

I transcribed each interview using English grammar, so as to make them as easy to read as possible, while still retaining some sense of the verbal flow and indicating the non-linguistic, such as pauses or laughter, for example.

A hermeneutic phenomenological analysis approaches texts with empathy with the aim of expressing the experiences of participants, staying as true to their words as possible (Langdrige, 2007). To achieve this I employed the three methods of reading; ‘holistic,’ ‘selective’ and ‘detailed’ (van Manen, 1990). I began the analysis of each interview with a close reading of the text, moving on to the use of descriptive annotation, to form a holistic analysis. I then reworked this analysis by asking selective questions, exploring points and themes or following threads. Themes are a complex construction and in the approach I employed there is no simple process of codification. Headings were tentative at first and remain connected with the detail of the text, before being taken up at an integrative level of analysis so as to enable me to draw complex material together.

When I had analysed each transcript using these three forms of reading I brought them together in groups of three or four. I was then able to draw similarities and contrasts across accounts to form the five analysis chapters. In the process of writing and rewriting, up through these forms of reading and analysis, key issues emerged and

themes were refined. As I described these, I retained brief passages of interview material, as excerpts which best express the essence of that which is experienced by participants. I used themes, therefore, as heading under which areas of understanding were developed, rather than as an attempt to ‘categorise the ontological field.’

Max Van Manen recommends the use of ‘free imaginative variation,’ which requires us to consider how the experience of a phenomenon might feel without a given theme, how experiences would be different if narrative identities were changed or if some aspect of the life-world were absent. For example, I found that accounts of decision-making brought people into being by connecting their emotional disposition with an act of rational calculation within a social context. I found myself wondering what different narrative identities would be expressed if different emotions or social contexts were substituted in the rational calculations that participants described. How would a worker be understood if they were excited by risk rather than concerned by it? How would someone who is depressed be understood if their social situation gave them every reason to be unhappy? This enabled me to recognise clear patterns in the texts.

In my thesis, patterns are observed to arise as a consequence of particular conditions of human existence, which I charted out and observed through the analysis. Unlike other research methods, phenomenological analysis makes a distinction between appearances and essence. It is possible through reflection to bring into awareness that which tends to be obscure; aspects of experience which otherwise lie beyond our routine means of understanding everyday life. This required that I moved

continuously between part and whole in a hermeneutic circle, as I returned time and again through my writing to the experience of participants (van Manen, 1990).

Reflexivity

I have written in the first person in this and other sections of the thesis so that my presence can be recognised in the study as the author. Van Manen (1990) recommends that the ‘I’ form, the ‘us’ form, or the ‘we’ form are used to evoke shared understanding (Although care is taken as an over use of this style might make the narrative less accessible for the reader). Having engaged in the process of completing a PhD, studying part-time over many years, it is no longer possible for me to employ a remote and impartial stance. It would not be appropriate to narrate material from a technical or non-personal position. I have become deeply engaged with the topic, experiencing an intense awareness of its complexity and its significance. I have given the topic my attention time and time again in the routines of my life as my thoughts are taken back to experiences of making decisions in mental healthcare and I have interrogated this phenomenon from the core of my involvement with it. The value of my analysis is in the depth of my encounter with the topic; it is not just a report of data ‘which I have had sight of,’ it is somewhere ‘I have been,’ where ‘I have lived,’ where ‘I have found my way around.’

Reflexivity can be understood as operating in three different forms;

- Personal reflexivity* - observing the effect of oneself as an individual
- Functional reflexivity* - observing the influence of one’s role as a researcher
- Disciplinary reflexivity* - a critical stance towards research in the context of debates about theory and method (Langdrige, 2007:60).

Phenomenological analysis is, like other research approaches, applied in a structured and systematic manner. But it is influenced by the researcher in the three ways listed above. I cannot suggest, therefore, that I have employed a pure or pre-established means of achieving precision. It cannot be said, in a simple manner, that a methodology is distorted or biased because it is mediated by my human failings as a particular researcher. The analysis must always be mediated by the nature of the researcher, because that researcher experiences the research process as an aspect of their own lived being. The exact method employed by the researcher must therefore be a personal experience they have lived, not just something they have enacted or adopted in imitation of someone else's research approach (Langdridge, 2007). As the researcher, I cannot be reduced to a replaceable agent in a preset procedure.

Reflexivity is described as a careful blend of introspection with an understanding of the interpersonal nature of emotion; an approach which should not be self-indulgent but is most effective when used as a springboard for insight and interpretation (Finlay, 2003). Reflexivity should not be used to make a claim that the research findings are more real or to simply subvert the claims of other researchers (Gough, 2003).

Personal reflexivity

I note that although I did not gain a professional training, I have held a leadership or managerial role in mental healthcare for many years. In this role I take responsibility day by day for agreeing decisions about care and treatment and I mediate where different understandings, agendas and expectations are expressed. I find that emotional or psychological distress is accounted for through different professional knowledge systems along with many informal understandings. This topic is therefore

a central concern for me. In recent years I have published work and spoken at conferences, attempting to describe the complexities of this work from a perspective which is not subsumed within one professional discipline, or defined as ‘service user’ or ‘carer’ feedback. But where there are entrenched conflicts it is hard to speak with an individual or independent voice. I want to say something that does not just feed into tired or redundant disputes; something which brings fresh thinking and new understanding.

Conducting this study has changed me as I have found myself making decisions in my employed role with extra levels of understanding. In writing reports, for example, I have not been able to maintain the illusion that I describe symptoms of mental illness as a neutral observer. I find myself co-constructing accounts in which different versions of the past are contested and different possible futures are brought about or closed off. This can at times be distressing as I am more emotionally engaged with moral dilemmas. When presenting evidence to a Mental Health Tribunal, for example, I am asked if the patient has ‘insight into their illness.’ I notice the rhetorical aspects of this question and wonder if practitioners have insight into the complex forms of accountability and stake inherent in the construction of illness and associated identities. Working on the PhD has enabled a deeper understanding as I try to come to terms with the complexity of human existence in my work context.

Functional reflexivity

I looked for the freedom to examine this topic from a position outside of the constraining knowledge systems of my employment. These systems limit creativity, while imposing meanings and choices. However, in entering a research process I am

again taken up in a flow of imposed meanings. In making a research proposal, seeking funding and applying to ethics committees I am caught up in established understandings and the interpretations of others carry me away from my own thinking.

I have reflected on an experience in which one of the study participant and I discussed how he had been diagnosed with schizophrenia and what this meant. He said he would *"Drop into a bubbling spring and carry on, sink beneath their wisdom like a stone."* (Ben: 1183-1185). My thinking developed in response to this through the use of this metaphor. The participant experiences his own substance and he sinks beneath the babbling words of experts. The knowledge systems and meanings which flow around him do not disturb his solid existence. In contrast, I am engaging with the turbulent flows of theoretical debate. I attend to the possibilities that are generated by different understanding of my position as an employee and a researcher. I find therefore that I do not sink and am caught up in a flow that will carry me who knows where. But whether we are open to different views or not, our being is lent substance by the understandings other people apply and this takes us to places we would not necessarily choose to be.

Processes such as applying to Ethics Committees often pulled me back into the understandings of my work setting. However reflexivity was then a useful means of harnessing my discomfort and confusion. I was for example required to categorise participants as 'patients,' 'workers' or 'carers,' before meeting them, while this was inappropriate within the methodology I employed and many participants could fit within more than one of these narrative identities. This was difficult because I was

again confined by the manner in which people are understood. I took note that the narrative role of ‘researcher’ grants some freedoms while also imposing limits, in just the same way as my employed position. This insight enabled me to understand that participants also face limits and freedoms in the various narrative roles in which they are understood. For example, those who were treated by mental health services could not choose to take part in my study as independent agents; because they were thought of as vulnerable, I was required to discuss their involvement with their psychiatrist. Meanwhile those who worked within services or acted as carers could choose, because it was assumed that they were not vulnerable.

Finlay (2003a) describes how she moved back and forth in a kind of iterative dialectic between experience and awareness, immersing herself in multiple layers of meaning. She developed an approach she calls ‘Hermeneutic Reflection’ influenced by Martin Heidegger’s notion of the Hermeneutic Circle, which flows, firstly from a fore-understanding, to secondly meeting a resistance when interrogating experience and thirdly to an interpretative revision of the fore-understanding. I have found myself pulled away from my fore-understanding in the research process, taken along in flows of meaning while resisting this. But by interrogating this experience, though trying to stand outside of it, I have revised my fore-understandings. In this sense I am able to apply my chosen methodology and to hold onto the independence required in the role of researcher.

Disciplinary reflexivity

I did not want to reduce my thesis to an interdisciplinary dispute, so extra difficulties were encountered when participants referred to the formal causal models of biology,

psychology and sociology. I found it was helpful to think of these references as metaphorical. In everyday language and in mental healthcare people talk about symptoms as if there is a 'disease process,' as in a physical illness, but this need not be taken literally. Ricoeur (1981) locates metaphor both in the construction of knowledge and in the construction of narrative identities in a context of time, culture and agency. Mental distress can also be spoken of as 'a computer malfunction' or 'a repressed desire' or an expression of social stress in which the person is compared to 'a damaged cog in a machine.' I approach these references in Ricoeur's terms as dead metaphors which have settled in the sediments of systems and bureaucracies, no longer enabling human creativity. Although at the same time they can be useful clues to the experiences of participants.

In addressing the concern that scientific enquiry might impose oppressive forms of understanding, Max Van Manen refers to the work of Jurgen Habermas (Habermas, 1972). Habermas argues for the use of a philosophy based on practical action and emancipation. I do not ask, therefore, which theoretical model is more true or accurate, but explore instead, what are the consequences for people if one or other means of understanding are adopted. Theoretical models can, therefore, be understood as metaphors which are expressed in stories, generating semi-fictional connotations. I cannot accept or refused these by reference to claims about objective truth or reality. But in phenomenological enquiry the only reality we can encounter and share is that of the individual participant. We cannot say that an understanding of mental illness at a social level is better or more accurate than an understanding at a biological level. The aim of this study is not therefore to reduce to models so that behaviour can be predicted, but is more akin to what Polkinghorne expresses when writing;

“The goal of research in the production of meanings is to produce clear and accurate descriptions of the structures and forms of the various meaning systems. This type of outcome does not provide information for the prediction and control of behaviour; instead, it provides a kind of knowledge that individuals and groups can use to increase the power and control they have over their own actions.” (Polkinghorne, 1988: 10).

Metaphors are ‘illustrations’ that can be closed off from scrutiny (Le Doeuff, 1980), selectively projecting implications (Black, 1979). I am not, therefore, observing metaphors from a neutral position, because I already understand the research topic within a complex set of these metaphoric constructions (Schon 1979). I attempt to set these aside through the analysis process so as to generate alternative and more creative or constructive means to understand our human condition. Metaphorical constructions act like a telescope or a microscope. We are looking through these established instruments, but are also at the same time being observed by them. Those who look into a metaphor can only see one relational structure or logic, while those who are being seen by it are limited in their dimensions and possibilities (Shotter, 1993). Disciplinary reflexivity is required in the difficult task of stepping outside of these restrictive fields of vision both as the observer and the observed.

Phenomenological enquiry attends to different metaphorical constructions as a means by which research participants seek to express their experiences. But this is not an adequate application of reflexivity if it fails to attend to the metaphors which appear in the epistemological framework of the research process. Metaphors are employed in describing our social world, in which society is thought of as having the structure of a

biological body, or a machine like mechanism, as if it has the dynamic of language, or drama and game (Brown; 1976, 1977). These are all representing the ontological sphere within one narrow structure so that data can be presented in a theoretical framework.

Highly structured research approaches might enable researchers to feel that they have discovered truths (Alversson & Skolderg, 2000). Alternatively, research processes can be compared to a ‘detective novel,’ as in solving a mystery. Or in the thinking of critical theory, in a postmodernism paradigm, researchers might be inspired to express parody, irony and scepticism (Finlay, 2003); while notions such as ‘defamiliarization,’ ‘cultural criticism,’ ‘true fiction’, ‘rhetorical constructs’ and ‘authorship’ are evoked within these approaches (Alversson & Skolderg, 2000). I have found that creative writing techniques are useful in deconstructing the metaphorical frameworks of established research, as Finlay suggests. However, this is held within the technique of imaginative variation (van Manen, 1990), because as observed by Finlay, it is easy to lose the grounds on which one’s own understanding is established when attacking that of others.

In contexts where complex and competing interpretations are expressed, metaphorical constructions can become mixed, adding layers of complexity. Research might be understood as a struggle with the multiple, ambiguous and slippery connotations generated when metaphors interact (Alversson & Skolderg, 2000). This is an engagement with the refractory nature of the subject matter and of our understanding processes (Haraway, 1994). However a seed that is planted through a subtle metaphorical inference will grow stronger than the dead wood of worn out theoretical

constructions; so new metaphors are a significant means of changing our world and ourselves (Ricoeur, 1981). The analysis process attempts, therefore, to develop new metaphorical constructs.

Ethics

I paid attention to issues of ethics and power while conducting the study. I submitted an initial research proposal to the university and developed a study plan, leading to a protocol for the research approach. I gained permission from the Open University Ethic Committee for an initial pilot interview. This was conducted with a participant for whom permission was not required by NHS or Social Services Ethic Committees. However, when I had refined the research approach I did then gain permission from these second two Ethic Committees. I took care where different forms of access to power or status might hinder the research process. However, in the use of a phenomenological approach it is not enough for the researcher to simply meet professional standards. The reflexive process requires a closer examination of power in relationships, as explored below.

Peter Ashworth (1996) observes that it is very difficult to achieve *epoche* when the research topic has to be introduced to participants as about something; the interview material would otherwise consist of directionless conversation. As I introduced the research study, it was inevitable that questions would arise, such as; ‘how much are people free to choose what they want to say and to what degree is interview material influenced by the researcher?’ I might claim that decisions are always mediated through interpersonal encounters and the notion of individuality is illusionary. On the other hand, I might hold with the phenomenological research principle; that we can

only gain access to the nature of reality, whether it is shared with others or not, through the experiences of an individual. I found a solution to this by waiting to find out how these concerns were experienced and expressed by participants. Although these principles are part of the methodology, their influence on the researchers thinking in the process of analysis must be suspended through the use of epoche.

Participants and researchers cannot easily step outside of their own separate existence in life-worlds which might often be very different. In the study I could be viewed an insider in some of the analysis chapters but not in others, adding complexities to the process of reflexivity. My social role as a mental health worker and manager would be seen by some participants as representing power and the holding of authority over them. So there is clearly a concern that these participants might not make reference to their experiences, but instead, they might manage their appearance in the face of that authority. However, employing a research approach within which varying narrative views are expressed is more clearly linked with the sharing of understanding as equals (Strong & Sutherland, 2007).

Relationships between different groups in society are mediated by contested understandings and experiences. It is a challenge, for example, to bridge a gap between 'zones of personal relations' (Halbwachs, 1925 / 1992; Middleton & Brown, 2005), where, for example, people who are detained under mental health law are likely to understand this process in a very different manner from those who enact that detention. I had designed my research approach with the intention of respecting, supporting and opening up each participant's experience, but in a setting where there are these extreme forms of conflict, this can be a challenging experience. My own

narrative identity might be questioned if I were drawn into these conflicts. I might be viewed as colluding with oppressive agents of power in society, so that distressing psychiatric treatments are more effectively imposed. Or I might be viewed as encouraging vulnerable people to understand themselves as able to choose not to take these treatments, thereby creating unnecessary problems and associated risks. It was difficult to interview colleagues when my questions might have prompted them to adopt one or other of these views.

Following Van Manen's approach, I tried to 'resist all forms of domination' in the sense that I held my self separate and responsible for conducting the enquiry. As the researcher, therefore, I could not simply rely on a status gained through my employment with a healthcare provider or as a researcher protected by ethical approvals. These positions did not lend my behaviour adequate legitimacy and I tried to reflect on my motivations and intentions. Entering into conversations with participants required that I opened myself to the possibility of different interpretations in which my status, value and motivations were in question. I was willing to engage in a dialogue of subversion in which narratives of authority were undermined. In order to see myself, alongside the self of the other, I worked with the reality that people in my position have abused and oppressed others. I was willing to accept a share of responsibility for this and to apologise where it helped participants to contribute. However, some participants who had been detained under mental health law still felt a lot of anger and some placed me under their scrutiny as a representative of mental healthcare, others placed me in the role of advocate, someone who might help them avoid regulation.

Despite my best efforts, it could not be expected that the attempt to hear the experiences of participants would always be successful or complete. Where I did exercise an authority associated with a social role, I needed to examine the dynamics of this. The use of the phenomenological method of free imaginative variation was useful again in asking what would be different if roles and positions of authority were changed. I made an attempt to set aside assumptions, which could otherwise impose moral judgements concerning subjectivity, such as; healthy or unhealthy; educated or uneducated; included or excluded. In this imaginative approach my attention was always drawn to ‘the practical application of any particular form of knowledge’. Again, my question was not whether a biological or a psychological analysis was more correct or true, for example, but what practical consequences were likely if one or the other means of understanding were taken up? This pragmatic question was associated with the ‘possibility of emancipation,’ which remained my central interest, motivating my active enquiry. My position in examining these consequences and possibilities can be open but it cannot be denied:

“We cannot remove ourselves from an equation in which we are part. Rather, our own encultured processes of interpretation need to be embraced as both the objects and the mediators of our investigations.” (Hawes, 1998).

Most research into the processes of making decisions in mental healthcare is conducted within one of the domains of biology, psychology and social or political theory. However, these aspects of our being are not separate in our lived experience of making choices. By employing a phenomenological approach I managed this complexity by looking in detail at specific experiences, asking how, given the nature

of varying roles and vested interests, might these experiences be understood by different participants in interactions. This seemed to be both a practical and an ethical approach.

The study protocol:

When I had gained ethical approval, I placed posters in the waiting rooms of community mental health services. Potential participants contacted me and for people who were diagnosed with a mental health problem, I made contact with the psychiatrist who was responsible for their treatment. I gained this practitioners opinion on the potential participant's capacity and any possible risks which might arise from involvement in research. Once capacity and safety issues were dealt with, I sent information sheets and made arrangements to meet in interview rooms at community mental health services. I described the study and explained its purpose, before gaining each participants consent to take part. I conducted interviews in a semi-structured manner. I had prepared a prompt sheet, to ensure that as many aspects of the topic were discussed as possible. However I used a conversational style of interviewing to enable participants to describe their experiences in their own words. I recorded sixteen interviews on an audio device. I transcribed these interviews into standard grammatical English to make them as readable as possible, while including non-verbal elements where these seemed significant, such as laughter or audible pauses ('erm'). I analysed these transcripts employing a Hermeneutic Phenomenological approach as described above.

Summary of the analysis chapters

I have brought analysed accounts together for an integrative level analysis and these are presented in the following analysis chapters. In Chapter 4 experiences of decision-making in mental healthcare are described by people who are employed as support workers or provide informal care to a family member. I explore common understandings of the nature of decision-making, related to mental illness and the bureaucratic systems of healthcare. In Chapter 5 I bring accounts together in an exploration of the experience of fluctuating moods. I consider the dilemmas that people face when responding to their feelings; ‘are these emotions prompted by their encounter with existence in time and place as mediated through relationships with others, or are they an outcome of disease processes or psychological maladjustment?’

In Chapter 6 I consider the experience of taking up a role as a mental health worker. Questions arise as to whether decisions are a personal choice in which we step up to take responsibility or an aspect of bureaucratic processes and interpersonal conflict in which formally recorded decisions represent uncomfortable interpretations which are imposed on us. In Chapter 7 I consider the impact of a potential for risk, along with the limitations of time and other resources. Participants describe their attempts to set priorities in making-decisions. Once again choices are presented as both individual decisions but are also governed by rational bureaucratic processes. Lastly in Chapter 8 I consider the experiences of people who have endured psychotic illness over longer periods. I discuss the possibility that they might make their lives meaningful in their own terms outside of understandings imposed by society. I then draw the material across these chapters together in the concluding chapter.

Chapter 4: we can be humans: Lay narratives

Introduction

This chapter introduces decision-making in mental healthcare by attending to the accounts of four participants who bring their own everyday expectations and assumptions to their encounters with these processes. John and Olivia are employed as support workers, while Mira and Naomi care for a relative who suffers from mental health problems. These participants are introduced in the Methodology Chapter and are described below. Each of them expresses their own point of view; providing perspectives which might be thought of as ‘common and everyday’ or as ‘lay understandings.’ The analysis includes decisions these participants make in their home lives, drawing a contrast between the formulation of these personal choices and the processes by which agreements are brought about in their work settings.

John is now in his fifties, from a working class background and he speaks about his own difficulties when his marriage ended. He then went back to college to train as a counsellor and has been employed for over five years in a community mental health team. He works to engage and support people who suffer long-term mental health problems and is White British.

Olivia has worked in a number of administration roles and has more recently taken on employment as a support worker, specialising in engaging people from marginalised ethnic groups. She speaks about

ending her marriage, which occurred quite recently. Olivia is also in her fifties, from a middleclass background and is White British.

Mira was born in a Middle Eastern country, to an upper class family, but moved to the UK with her family when they were subject to persecution following political changes. She is now in her fifties and is employed as a psychotherapist; she also cares for her brother who suffers enduring mental health problems.

Naomi is again in her fifties and lives in a rural community. She is married and has a part-time job as a youth worker. She cares for her daughter who suffers enduring mental health problems and she is White British.

Thematic summaries

Being human:

Notions of inclusion and personal control are explored. It is expected that a person should be free to act on their feelings, but also move towards their goals using calculated reason and thereby express self-interest. This is seen as natural, while professional decision-making is criticised as systematic or robotic. The use of psychiatric interventions which control people or regulate their moods is questioned.

Making decisions without emotional engagement:

Participants feel there is no emotional connection or trust between people in mental healthcare. This setting is experienced as judgemental, hierarchical and bureaucratic,

as preventing mutual decision-making and hindering natural human processes of self-expression, creativity or freedom of choice.

Capacity and responsibility:

Judgements are again questioned, where participants speak about difficulties they encounter when one interpretation is promoted by senior workers, while alternative understandings seem to them to be warranted. Responsibilities are disputed where people are thought to have a right to make their own choices, but if there is a loss of capacity responsibility is placed on workers who are expected to take control.

1: Being human

This theme explores the common understanding of emotion as an essential aspect of being human, along with the expectation that decision-making requires emotional investment. People are thought to be acting to promote their interests and following preformed plans, with specified goals, founded on the desires they experience. Impulsivity is acceptable, when a person is willing to be responsible for the outcome of their choices, while exercising control is also important. But these expectations create confusion and misunderstandings when participants find that workers in mental healthcare only make decisions under the guidance of senior colleagues, within a regulated system. The use of sedating medication might then be understood as an inappropriate means of controlling people; denying them the opportunity to grow, or express their own will. Participants find that when they express emotions in the setting of mental healthcare, their feelings are devalued or dismissed, so that they do not influence decision-making processes.

As a Support Worker, Olivia talks about helping people speak up for themselves. It is important, from her point of view, that people should be free to make their own choices. She is promoting this freedom in her employed role and she also gives examples of the freedom she experiences in her own private life. She expects that she should be free to act independently of others, that she should be in control, and that it is her responsibility to deal with the consequences of her decisions. Although, at the same time, she makes decisions closely with others where there are shared interests. She mentions two of her decisions; legally separating from her husband and sometime later, moving out of their shared home. She recalls her experience of the first of these choices as a relatively impulsive act, driven by her feelings; “*probably quite impulsive actually*” (Olivia: 117). This decision, she reports, did however involve a kind of mental calculation, but only after it was made, as she thought about how she would explain her actions to other people:

[laughs] I think I did actually, in an informal sort of way, to myself, you know, putting the pros and cons I did actually write the pros and cons down, [laughs]... I'd already decided, but, as a result, I suppose when you want to talk to somebody and say the reasons, you need a whole list of reasons (Olivia: 134-141).

Olivia just went ahead and arranged a legal separation from her husband, but then, when she decided to move out, this required a process of total agreement and negotiation:

For the moving house, obviously, that would be totally agreement you have to, negotiate all the time but for the, for the first thing and it was really, I was doing it, I wouldn't have had anyone else's, I just went ahead and did that (Olivia: 105-107).

Olivia's laughter suggests discomfort or exposure as she admits to making an important life decision based on her emotional disposition. Perhaps she feels under pressure because her reasonableness could be questioned if she fails to account for herself in a rational manner. There is no doubt a seamless experience at the root of this, but in her narrative, she connects her mental process more firmly with the negotiations and adjustments she must make in her relationships, than with the impulsive feelings in which she experiences the formation of her decision. However, the practical task of sharing out jointly owned possessions requires that the desires of all parties are considered and respected. Olivia took on the responsibility of negotiating agreement throughout. While in contrast to this, she believes that she is free to act on impulse, unilaterally and prior to any rational calculation, in ending her marriage.

Olivia expects that people should be free to act on impulse in response to their emotions, but also, that they must then be able to account for their choice as a rational means of fulfilling their desires. Perhaps then, it is this expectation, that decisions are primarily rooted in a person's freedom to choose which is causing concern for Mira when she encounters mental health workers. Mira is a family carer, who helps in looking after her brother. In recent years he has stayed in hospital or residential settings and his family meet with workers, as arrangements for care and treatment are reviewed. While discussing these encounters, Mira observes that workers cannot share

their knowledge or speak to her as individuals. She finds that they are bound by a responsibility to their professional systems. They are not telling her what they can do from their own sense of responsibility or freedom as individuals, but are part of a system. So she feels that she is not talking to or seeing the person, but is instead encountering a system:

That, knowledge, they cannot share, or tell me... a responsibility that goes with it, for them, so they are working in a system, and system, is their boss, and that the difficulty is, I'm not talking to the person, I'm talking to the system (Mira: 91-97).

I can see, the system, that people work in the system, because I see, for example, you become the the the representative of the system, but actually I'm not seeing you, I'm seeing the system, but in that I see you too but I can't have a communication with you (Mira: 113-115).

This is difficult and frustrating for Mira. She cannot get a sense that the workers she speaks with are acting as individuals, as people who make decisions in their own right as human beings:

They begin to work, in a system like robots, and and the difficulty is from the carer's point of view, from a user's point of view, I want to deal with humans because my brother is a human, I want them, be a human to him, and look at him from that side... They say we, well you know we have only one way, this is the only way, and and and it can become very frustrating and in fact very destructive, because many people in, my brother's situation, can be helped, actually, if the workers are allowed to, have some

creativity... They can't cope, and from my experience, you know, social workers, um, psychiatric nurses in particular the amount of times that I've gone into a system, people are ill, because they cannot be themselves (Mira: 131-147).

Mira is a practicing psychotherapist and she is clearly concerned to promote psychological health. She wants to deal with a human person, not a robot, because the person she cares about, who is receiving treatment, is a human being. She is frustrated by the manner in which workers tell her that there is only one way to do things; she believes people could be helped if workers were free to be more creative. Mira then goes on to compare her brother with a mouse in a laboratory. She suggests that workers cannot be themselves or make their own decisions and she senses a similar experience in which her brother feels that he has no rights and no voice, because decisions are based on systems of professional judgement; he cannot make choices over his treatment:

That's the painful hurtful, when you love somebody who has been, um like um a a mouse in a laboratory, to have these drugs and things done to them, and then and feeling you have no right to say; "No don't give it to me, I won't take this." (Mira: 439-442).

In Mira's experience, when workers require that her brother takes prescribed treatment, they are not sensitive to his emotional disposition or accepting of his impulsive choices. Also, it is likely that her brother will receive just the same treatment as any other person with his condition and he has no control over this. Workers are 'professional' in the sense that they cannot express a preference for

working with or helping one person before another. The system is fair and equitable, but this is not right from Mira's point of view. If workers achieve adequate standards this is not enough for her; *"It's not they are not doing their best, but in their best, it's not good enough."* (Mira: 76-77). Mira does not want a cold professional intervention, or the standard treatment for her brother; she wants an emotional charged human relationship.

John also experiences this contrast between personal and professional decisions. He talks about his life outside of work, a life in which emotions and relationships are bound up together. He decided to return to studying when his marriage ended and he trained as a counsellor. However, this decision was partly a reaction to the situation and partly something he was already thinking about:

It kind of was reactive although, although it it was already there, that that the thoughts about going back to college were already there, but yet somehow, the the marriage kind of break up, provided me with the opportunity... I needed to know what I'm capable of, because I didn't up until then, um, but also the real drive to kind of, to make my future different from the past actually, which had been quite, had been obviously very difficult (John: 473-479).

John says he needed to know what he would be capable of and he felt limited in his marriage, being driven to make his future different. This notion of personal growth is also important for Mira. She is critical of services when, although they might be accepting, they do not help people to grow; *"Accepting, people in their own skin in their own ways in their own behaviour, its one thing, um but, to help them to grow is*

another.” (Mira: 199-200). Also, Olivia explores this distinction which participants experience, between emotionally driven decisions which can build connections or cause severances in relationships, and choices which are negotiated, agreed, and more obviously rational:

I think some decisions you make in your personal life, can be made impulsively, not everything but obviously some, whilst I think if you are, you know you the decision to put someone on medication or put them in hospital you know, this is going to affect their life, tremendously so you've got to make sure. I mean for me to make decisions about my life that's my life, it's my, it's my problem if something comes about [laughs] but for someone to make a decision about someone else, it's got to be you know, well thought out and it should actually, that that is what is hard, because the person in front of you is going to be um, not having much control in it. (Olivia: 310-318).

Olivia is struggling to reconcile conflicting ideas. Her impulsive decision is again prompting laughter and is perhaps a matter which she wants to treat lightly. Perhaps she does not want her personal choice to be examined in a formal or serious manner; although she indicates her full commitment to being responsible. Rational examination might dilute the easy spontaneity of her choice by reading bland calculated self-interest back into her actions. But also, she will tolerate any unfortunate consequences of her chosen action, acknowledging the risks she is taking and she feels that she is in control. In contrast to her personal life, at work Olivia finds that there are decisions which are hard, or difficult, which need to be thought about and explored in depth. These work based decisions are not grounded on individual

emotion, choice or freedom. They are instead processes over which a person does not have much control, so how can people invest emotionally, when they cannot influence outcomes?

Olivia is also working with people who, she says, successfully managed their feelings through the routines of prayer or meditation in their religious practices, practices which do enable them to feel in control:

But when you talk about freewill, if someone wanted to stop medication and do their faith, that is their free, they have freewill. (Olivia: 399-400).

The notion of freewill is again a central concern. So this is not just about finding practical means to manage symptoms and religious practice is presented as something; *"They want to do."* (Olivia: 338). While in contrast to this, she knows people do not want to take psychiatric medication; *"Maybe three or four people I've spoken to, have said they would like to stop their medication."* (Olivia: 326-327). She talks about the success of people who are able to function by practicing their faith:

The thing is, some people who have been very ill, and I know two people who have actually stopped their medication, and they are functioning in a very, well what we consider normal way [laughs...] but doing things they want to do like, taking their faith and practicing their faith, quite religiously (Olivia: 335-339).

Again Olivia emphasises the choices people make, as they stop taking medication and are 'doing things they want to do.' She laughs when she speaks about functioning in a manner which would be considered to be normal, as if again, she is uncomfortable

with this idea that people cannot just be free, but that their choices are judged against some kind of normality; *“If they’re just can’t cope because the society is too rigid for them, there’re just as normal as everyone else, it’s just they want to act in a different way.”* (Olivia: 505-507). This notion of freewill, which is essential to Olivia in the manner in which she experiences decision-making, is for her, somehow at odds with psychiatric treatment:

You know they’re using a religion or faith to, bring routine to their life, but it’s still their decision to do that rather than take medication, which is very natural and that’s the other thing I want to say, medication actually numbs people a lot it’s very numbing um, so people aren’t actually feeling (Olivia: 425-428).

Medication in Olivia’s experience is ‘numbing’ and somehow not natural, in the sense that people are prevented from experiencing their feelings. She gives another example from her work experience, of someone who wants to feel emotions, particularly the fear associated with their past traumas. This fear, Olivia suggests, previously led this person to rely on medication, so this is not an easy path that they are choosing:

Someone said to me recently that they, they wanted to stop the medication because they felt, they wanted to feel the fear, and emotional, fear that they may have experienced, as a result of you know their past trauma that they had in their life, so they were so scared of that feeling that they obviously took the medication, it’s really worrying for them but now, they have stopped um the medication and, they can now feel that fear, and their feelings (Olivia: 432-437).

There is then for Olivia something important and real in the experiencing of emotion and the possibility of acting on impulse. This is connected with the notion of spirituality, a sense that life can be more open, more meaningful than that which would be expected in just following a safe or rational decision-making process. So although freedom can be worrying and there are dangers, emotions are a natural experience which people would want to feel.

Mira is making sense of psychiatric medication in a similar manner and she also speaks about the tranquilising effects of treatments. She feels let down by workers who care for her brother, because they just wanted to give medication and she finds that they cannot deal with conflict, they are unable to manage or defuse emotional distress:

They were not appropriate, they just are people who like to give medications and keep them quite, they don't know how to handle um crisis, mental health is not predictable, it's full of crisis all the time, and um, and you know and you need to, have those um, skills, of defusing the situation, learning how to contain a situation (Mira: 785-789).

In Mira's experience, crisis and conflict are inevitable in mental healthcare. Like Olivia, she views emotions as a healthy and necessary aspect of being human. Naomi, like Mira, cares for a relative and they both refer to crises, conflict and uncomfortable emotions in their encounters with mental health services. Naomi, for example, believes that her daughter's emotional distress is caused by biological processes, that she is mentally ill; while psychiatric workers did not share this understanding, suggesting instead that this distress was a psychological response to trauma. In her

account, Naomi describes how an assumption was made that abuse occurred in the family, based on a statement made by her daughter. Naomi believes that this was a 'psychotic outburst.' But she characterises the attitude of a psychiatrist as; 'not being in favour of listening to the family:'

A particular psychiatrist who seemed to favour, that most people suffering from, generalise generalising most people had personality disorders as opposed to allowing for the fact that the parents could actually know, that person better than them, and then through, the, result of the psycho the psychotic outburst, making an assumption that there had been an abuse in the family, and sticking with that. Now, if you base your opinion on, your own belief that a lot of people suffer from personality disorder, or behavioural problems as opposed to psychotic problems and, you've made up your mind that there are abusive situations in the family, then you aren't going to be in favour of listening to those who, might, actually, know a little bit better than that one person (Naomi: 177-186).

In Naomi's experience, parents have a privileged understanding of their children, and she is critical of a psychiatrist who believed her daughter's claims about experiencing rape. Naomi feels that she should be treated as a reasonable person; that her opinions, or feelings, should be heard and respected. But in contrast, she experiences her daughter as ill, so that her words cannot be trusted and should not be heard.

I don't think there was any excuse for that because, the psychiatrist in question had known us, had met us and had, taken the word of someone who was obviously very very ill (Naomi: 450-453).

Naomi felt affronted. She believed that her daughter was not given adequate treatment or support. Workers were clearly facing a challenging situation in which it would be difficult to enable both Naomi and her daughter to feel that their views and experiences are heard and taken seriously. However, the outcome was that Naomi does not feel that the notion of ‘decisions’ had any meaning for her or for her family. Mira also experiences this exclusion and she feels that at times, workers avoid contact with her family:

There was no such thing as decisions because, we were in the dark as the parents, um, and, looking back, we weren't consulted (Naomi: 24-26).

“That’s what we do, with users and carers, we don’t, we wont answer their phones, we wont do this” and; “Don’t do this because it’s too much and then, things will just calm down,” so, the madness in the system is a huge avoidance (Mira: 486-488).

In Mira’s experience, workers are caught up in the chaos of their work setting, so they do not have time to answer the phone or respond to people. Mira observes how these workers can therefore avoid engaging with them and then emotional intensity or commitment dissipates. Naomi also experiences intense and troubling feelings, which are not heard and she describes how she pleaded for help, referring to her extreme concern for her daughter and the apparent impervious attitudes of workers:

We actually felt that nobody would listen to us as a, as caring parents, um, until, life got very very difficult, um, and then I pushed for help (Naomi: 31-32).

By pleading for help, and um, pleading with the manager, pleading with God knows until the point where they can see that we're actually serious about this (Naomi: 674-676).

There is a disgruntled quality to these accounts in which Mira and Naomi feel no one listened to them or their families. They expect their persistence and their heightened emotionality should influence workers so that concerns would be heard. But their emotional distress did not actually cause workers to listen, and this distress might be heard instead as unreasonable. Perhaps, in the terms which Mira and Naomi employ, within those apparently robotic and rational healthcare systems, extreme emotional distress can only be thought of as an inappropriate or pathological behaviour. However, Naomi reports that her family is now supported by workers and; *"Because of their support we we're able to, feel like human beings again, all of us."* (Naomi: 699-700).

In the experience of these participants, there are different means of making choices. On one hand there are the apparently inhuman systems of mental healthcare in which workers are acting like 'robots,' as rational interchangeable agents. Emotions are dismissed or viewed as symptoms of illness and the treatments that are prescribed in this system are described as having the action of numbing distressing feelings. On the other hand, there is a desire for emotional contact in which people can feel human and experience their feelings, even though these might be distressing and difficult to understand or manage. But participants who express extreme emotional distress are not heard in mental healthcare, their feelings do not influence decisions. So, unless care is taken to ensure people feel included, they can find 'things are done to them'

and that they ‘feel that they have no right to say no,’ they have no control and no emotional stake in the decisions others make about them. But there is also a contradictory expectation that when it is thought someone cannot take control, mental health services should impose regulation on them. But for these people who stand outside of the institutional system, there is a hope for something spiritual; a hope that life can be more meaningful than just following a safe, rational and mundane treatment procedure.

2: Making judgements without emotional engagement

In this second theme, participants describe their experiences of hierarchical decision-making. Participants who care for a relative feel emotionally connection with some workers, but they find that these workers cannot influence the decisions made by more senior colleagues. Meanwhile participants employed as support workers do not feel able to make judgements about people they do not know well and they express surprise when qualified workers categorise behaviours within diagnostic classifications after just one initial assessment. These support workers describe their difficult position in these assessments. They are sometimes invited to contribute to professional judgements, but they believe they are employed to promote the views of the people who are assessed. There is an idea that they might meet them halfway and mediate in decision-making processes. But their views are not often heard within the systems of healthcare decision-making.

Participants speak about needing to feel that they are treated like human beings. They can experience themselves in this manner within their relationships with some

workers. Mira criticises hierarchical decision-making and feels that decisions should be made in relationships where there is an equal access to power:

The psychiatrist was, he he's the one who made decisions always, and the and even I remember the frustration of the psychiatric nurses... We had communication with them in a human place, they saw what I heard. But they were powerless in in those decision makings... And to me giving so much power to just one person in the team, that's dangerous, that becomes like a hierarchy, kind of um, you know it's it should be collective (Mira: 448-456).

Mira experiences human relationships with psychiatric nurses and she hears their frustration with a psychiatrist, who makes decisions with which they disagreed. She believes there should be a more shared or collective quality to decision-making in this setting.

John is also concerned about this hierarchy in which the psychiatrist's opinion carries the day, because they carry the responsibility:

There is a hierarchy around decision making so, I mean obviously particularly in the clinical meeting, and I guess ultimately because they they carry the responsibility, usually whatever the psychiatrists kind of say um kind of carries the day really... The role that someone occupies so, you know for instance a a support worker might have a particular point of view, or a psychiatric nurse or an OT, might have an opposing view point, and in my experience, it's usually, the person who, is further up the hierarchy who will carry the day (John: 31-54).

In John's experience it is usually the person who occupies the most senior role who decides what should be done in mental healthcare, even though other members of the clinical team might disagree. Workers employed on lower grades do not have the power to influence decisions.

Naomi also talks about this lack of power, where some workers believed her account of her daughter's mental health problems, but the psychiatrist did not; *"So we had support from people, from staff, who would believe that, but were powerless to help in altering decisions."* (Naomi: 58-61). Like Mira and John, Naomi finds that there are disagreements between workers on different grades, but that the more qualified worker's decisions would rarely be challenged.

John's senior colleagues make judgements about the causes of behaviour, as either mentally ill or just behaving in a manner which is challenging:

I think, when judgements have to be made, with regard to what is kind of driving that behaviour is that, is it that behaviour being driven by by kind of poor mental health, or is that behaviour, kind of, is it behavioural?... I wonder how we're able to do that objectively, cause you know that sounds like in its self, quite quite a big ask clearly, to be able to arrive, at that, those conclusions (John: 424-436).

John is not confident that clear judgements can be made and Olivia expresses similar concerns. In her work role she attends meetings to support people, while professional workers assess for mental health needs:

I was quite amazed, that the worker, who could actually judge, I mean I don't think this I don't think the worker knew the man, it was the first time he had met him, so I was actually quite surprised how, he could just judge him, like that you know, because sometimes people could, you know you know it's not always clear is it? (Olivia: 251-255).

Olivia is amazed and surprised when a qualified worker makes judgements based on one brief meeting; while she does not find these matters to be so clear cut. As a support worker, Olivia stands outside of the process of making judgements. But she feels under pressure to contribute to decisions, although in her understanding, this is not part of her role. Instead she encourages the person she is supporting to speak up:

I was going to support, not really as an advocate, because that wasn't my role, but I did feel that the mental health worker, was sort of asking, decisions, but also looking at me, as if, wanting to get my, views as well which I didn't actually feel, I felt that I had to be encouraging the person I was with to do all the talking (Olivia: 190-194).

Olivia is concerned that mental health assessments are based mainly on professional judgements and John explains that it is not easy for someone on a Support Worker grade to contribute to decision-making processes. This can feel invalidating, because his point of view would not influence the decision-making process and, most often, the opinions of senior workers prevail:

It, can be very difficult to make myself vulnerable um, in in bringing in my point of view forward um, it has been risky at times because, because if, if someone in a senior

position disagrees with me, then I've often felt that that their point of view has prevailed, and mine hasn't, and that kind of feels quite invalidating really so that, that can be kind of quite hard, that can be difficult (John: 186-190).

Because he would be making himself vulnerable, John finds it is hard to bring his point of view forward. He refers to his experience of taking up an employment role with the N.H.S. and observes that this requires that he works with a bio-medical understanding. He finds that there is an expectation that workers should be given the status of experts and he recognises the common claim that people do not understand their mental health problems, because they do not agree that their behaviours are caused by a disease process:

When you operate within the N.H.S. you you do operate within, a kind of bio-medical model, um, that, that assumes that that the practitioners are the experts, and, you know that that the client... 'the client has no insight' (John: 149-152).

John trained and is qualified as a humanistic counsellor and he observes that the client's perspective is often different but; *"It's no less valid."* (John: 165). He is open to the possibility that there are different and often opposing understandings at play.

Olivia suggests that a support worker might have a mediating role, in trying to meet someone halfway between contrasting positions; *"They could have a Support Worker couldn't they, if they were sort of half way."* (Olivia: 62-63). John and Olivia do not feel comfortable if they are asked to contribute to the process of making professional judgements. They experience themselves as standing outside of the mental healthcare

system, mediating between people. In this ‘halfway’ position, John is more aware of the mutuality of relationships. If there are problems this is not caused only by the disposition of the person who seeks help. Sometimes problems are caused by the emotions (or the rationality) that workers bring to the relationship:

If there are ructions in our relationships with clients, we also need to look at ourselves and our part in that, it's not a one way process, um, you know, we're we're, we exist in relation to other people just as they do, to us, and if there are ructions, it's no not not necessarily just about, what they bring to that it's also what we bring to the table (John: 227-232).

John is clearly aware that mental health workers do have emotional responses to the people they serve and that this cannot always be hidden or ignored. However, his understanding does not fit with the interpretations of his senior colleagues.

The decision-making processes in mental healthcare can then appear inconsistent, or led by bureaucracy. Naomi recalls how workers would cite policies on confidentiality and she observes the manner in which priorities shift and change, so that if she is listened to now, this might not be genuine concern, but just an outcome of changing service priorities. She observes that services have audits and targets and that it is only more recently that involving carers became important:

Not just from the point of view of hiding behind um, confidentiality, but, also because, carers with capital letters weren't considered a particularly interesting subject at the time, it hit the the targets or tick list later (Naomi: 51-54).

For Naomi, it is clear that workers have something to hide and in her experience there are ‘two sides;’ *“It’s almost that, the defensive words that make one as a carer, feel there are two sides.”* (Naomi: 846-847). Naomi sees workers using systems and policies to disguise their true feelings, to enable them to make the choices they favour while excluding families. Similarly, Mira observes that, while ‘the system is the workers boss,’ these workers might use the chaos this causes, so as to avoid developing emotionally committed relationships.

Qualified mental health workers make judgements about people with whom they have only a superficial relationship and participants are concerned that unless time is taken to know someone, only one point of view will be heard. This raises the question; ‘if someone is not involved in a decision, how can they be held to account for the outcome?’ Also, decision-making in mental healthcare can appear to be an outcome of apparently arbitrary targets and tick-lists, or changing policies, which are disconnected from the basis on which everyday choices are usually made. So, on one hand, the truth of an emotion can be based on the intensity with which it is felt, within an established and complex relationship. While on the other, the truth of a professional judgement can be based on the degree to which it is remote or dispassionate. Professional judgements are influenced by seemingly abstract and shifting notions of effectiveness and rationality, while carers are human, they ‘care.’

3: Capacity and responsibility

It is difficult for participants to reconcile tensions between different assumptions. A degree of impulsivity, for example, is possible in a person’s own private life, but this kind of spontaneity could not be accepted in contexts where there are concerns about

power and capability, so that a more rational approach is required. Although participants criticise senior workers, claiming a diagnoses is based on personal and biased feeling for example, it is still expected that these workers should take responsibility and resolve risks. But in contrast, an ability to express one's emotions is experienced as an assumed right without which joint decisions cannot be made.

The participants included in this chapter also assume that unless people are involved they will fail to invest any emotional commitment or they will not accept choices as their own. However, this is not just about whether someone is involved or not, it is also about who is believed, or what kind of understanding prevails, as different accounts of events might be given.

This section explores different assumptions about rights and responsibilities, which are imposed by conflicting forms of understanding. Social and psychological interpretations, as expressed in recovery philosophy, stand in contrast with the biological understanding of a medical model. An exercising of power is experienced when senior workers impose judgements about people who are seeking help, by making decisions within the logic of one or other of these ideological constructions.

In her account, Naomi understands her daughter to be suffering from mental illness and this was clearly in conflict with the judgement of a senior worker. But how would workers decide whether they should believe Naomi's account, in which a reference to the crime of rape is no more than a symptom of mental illness, or should they believe her daughter? At first Naomi's daughter was believed, then, according to Naomi, it was decided sometime later that this young woman was suffering from a mental

illness. These matters can only be approached here through Naomi's experience and she describes how she was unable to understand her daughter's behaviour; then, when she sought help, she was distressed because workers made enquiries about sexual abuse in the family. But Naomi had already decided that her daughter's claims about rape were a delusion and she saw no evidence that this young woman was making rational choices:

She wasn't not eating, cause she was choosing not to, she wasn't not changing her clothes (because she was covered, in menstrual blood), cause she chose not to, it was because she couldn't (Naomi: 960-962).

Mental health workers might understand Naomi's daughter to be choosing not to eat, or choosing to wear blood stained clothes, so as to express her distress. They could view these behaviours as understandable responses to experiences of sexual abuse and rape, but Naomi did not. She is also concerned by the implied responsibilities and meanings attached to these different interpretations. She explains, for example, that when her daughter's claims were believed, workers did not require that any treatment should be administered. Instead, time and space were given, so that this young woman could make her own decisions about accepting support or therapy. But Naomi expected that these workers should impose interventions on her daughter, who she believed, had a right for her illness to be treated. She expected that workers should make her daughter eat and make her wear clean clothes.

Naomi makes a connection between capacity and responsibility. John also picks up on this connection as he talks about the notion of 'recovery.' For him, this means that

people will only regain their mental wellbeing when they take ownership of their own life situation; when they have goals which they are working towards. He is, therefore, working with psychological and social understandings. John observes that this is not an easy approach and that it would be unhelpful for practitioners to put pressure on people who are not emotionally engaged with proposed decisions. He views this as ‘dragging the client by the arm.’ He suggests that it is better to speak about aims and then gently hold their hand as they go along a road; a road which is likely to be really difficult for them:

If you start, metaphorically, dragging the client by the arm then what you will be met with is resistance and it wont work, and you will achieve the opposite of what you are trying to achieve, I think metaphorically I would rather, be kind of speaking with the client about, you know, what what her aims might be, what are their aims for themselves... Getting them on board with it, and and, gently holding their hand as they go along that, that what is likely to be a really difficult road... To be putting pressure on clients and not having them fully on board with it and then being met with that resistance which, will just, you know, it will be anti-therapeutic (John: 259-272).

Too much pressure to commit to agreements and follow them through is, in John’s view, anti-therapeutic; it will achieve the opposite of what is intended, there will be a conflict of will. But also, in John’s account, the responsibility for making decisions is again aligned with a kind of capacity. He is describing his work with someone who can choose whether to accept help or not.

When it is thought that a person is able to make choices, then they can be held to account. However, if it is thought that a biological illness might cause risk, it will be the team's responsibility to resolve those risks. John feels, however, that his colleagues are being over protective and inflexible in the degree to which they take this responsibility on. He says that within this approach, the person he is trying to help is not going to take any responsibility at all:

There is a very robust, um, crisis plan in place but ultimately, if she doesn't respond to that, then we send the cavalry round, and and she's usually sectioned. Now what I would say is that that in my view that's a kind of backward step really... because she knows that ultimately the cavalry are coming round, she doesn't, in my view, respond to this in a way that she used to, because she doesn't have to take responsibility for her mental health any more (John: 104-112).

John feels that the team he works for is rescuing this woman, rather than enabling her to take on more responsibility for maintaining her mental health. This is similar to Mira's concern that mental health services are not helping people to grow. But this is not just about neglecting to help her 'recover.' John believes that it is actually more risky and is probably wondering what would happen if the team were unable to make a visit on a day on which she is neglecting to take treatment or failing to manage her mental health problems in some other way; *"So she knows that we we are having to go in there and if you like, we will rescue her, but actually in some ways in its self, that's pretty risky."* (John: 116-117). In John's experience, this woman will not now take action in the expectation that workers will arrive to ensure her safety; she does not take responsibility for maintaining her mental wellbeing.

Naomi understands her daughter as; “*Probably ill enough not to be in a position to think.*” (Naomi: 114-115), but John did not find this biological interpretation useful when trying to help someone to maintain their safety. However the more qualified workers decide and other people must try to work with their interpretations. Beliefs about mental health problems as a form of illness are common and these difficulties are believed to influence a person’s decision-making in a manner which they cannot control, so that they cannot be held to be responsible for the choices they make.

This last theme has identified a core experience in which different understandings impose rights and responsibilities. Participants speak about feeling excluded from decision-making processes in mental healthcare, describing experiences in which their understandings are not heard, their expectations are not met. The manner in which different interpretations can be promoted by more senior workers is a significant exercise of power. The experiences described in this chapter are, therefore, not just about whether someone is involved or not, it is also about whether they are believed, what kind of understanding prevails. These understandings include ideas about the causes of mental distress, as they are thought to operate at social, psychological or biological levels. These interpretations impose different understandings of a person’s capacity, implying different potentials for taking action and then being held to account.

Conclusion

In this first analysis chapter, common expectations and assumptions are explored. There is an expectation that people should be able to exercise control over their lives, so that they are free to make choices based on their emotional impulsivity, as a means

of expressing their individual will. Human desire is expressed in the impulse to remain open to new possibilities and the person expects to be responsible for the success or failure of the actions they choose. Acting in response to feelings is then seen as an essential personal freedom, which people are not able to exercise when their rights and responsibilities are denied to them, where they are unable to influence the outcome of decisions which affect their lives. This creates an uncomfortable tension for participants. When the quality of being human is denied, is not enabled, or is otherwise lost, they want mental health workers to provide both freedom and protection.

Humanistic notions are adopted by participants in this chapter in which important personal decisions should be experienced as having an emotional quality, driven by a desire to take up opportunities, in a movement towards self actualisation and self expression (Maslow, 1962). Participants bring ideas concerning the positive potential of human beings to the setting of mental healthcare. Those who are employed as support workers, for example, speak about their attempts to mediate between people, where different understandings and expectations are expressed. They are trying to ensure that people are included in important decision-making processes, so that everyone will feel that they are following their own will. These workers experience an emotional connection with the people they are trying to help, although they can then have a sense of powerlessness, when they find that their efforts do not have an impact within the hierarchical decision-making processes of their work setting.

Although the support workers who contribute to this chapter are employed in mental healthcare, they stand to a degree outside of these systems. They are trying to gain the

trust of the people they are helping and are then critical of senior workers when they do not take the time to know someone. The issue of gaining trust is taken up again in Chapter 6, where workers talk about their attempts to meet people as equals. The challenges of overcoming differences in the ability to exercise power are considered, where participants try to interact with people as fellow human beings. Democratic notions of equality are expressed in the expectation that professional helpers should step beyond the limitations of their employment roles, to meet people somehow as fellow human beings, as discussed in by theorists such as R.D. Lang (Laing, 1967). Participants across these analysis chapters are trying to accommodate these ideas as they negotiate mutually agreed decisions. A degree of pressure is experienced, therefore, where workers are expected to meet organisational agendas, whilst also being human; being a person who enters into and maintains an emotional connection with another person.

Along with their hopes for self-actualisation though emotionally involved decisions, participants in this chapter bring understandings which highlight inequalities in the exercise of power, where some people cannot promote their own interests. Mira and Naomi speak about being in conflict with others, for example, when they experience the decisions of workers as opposed to their own personal preferences. They experience themselves as brought in to being by knowing themselves as human or as 'caring,' for example, through their emotionality which they place in contrast with the apparent lack of care expressed by professional workers. The accounts given here suggest therefore that it might be quite difficult to meet everyone involved in complex conflicts as an equal, where sharply different personal understandings are experienced. It is difficult to build trust in relationships where these different beliefs are expressed.

However, a lack of trust in relationships does not mean that there is no emotional connection and this will be explored in further chapters. Decisions are clearly made when there is an inequality in the ability to exercise power. In the following chapters the experiences of participants are explored where decisions are the outcome of interpersonal emotional pressure, flowing between people, rather than a fulfilment of a hope or desire which originates within an individual. It cannot be assumed therefore that the individualist ideas and assumptions which participants express in this chapter are more natural or human, or correct in any sense.

A phenomenological approach is designed to open up the experiences of participants so that they can be understood and R. D. Laing made a significant contribution in exploring the worlds of people who are diagnosed as mentally ill. Rather than dismissing the experiences of these people as meaningless, in the sense that perceptions and beliefs are understood as no more than random symptoms of an illness process, existential analysis is used to make sense of these phenomena. A hope develops therefore, that by sharing experiences we might help others to understand what is happening for them, so that they might take control of their lives, enjoy their freedoms and contribute to our societies; societies which will then become more inclusive and democratic. However humanistic philosophies are mainly popularised within our modern western societies. While they help us to recognise that our individual human nature is central to our decision-making, they might also be taken up in a 'regime of knowledge,' which influences the manner in which power is exercised in this particular period in our cultural history (Foucault, 1969). They are perhaps an aspect of psychological knowledge in which people internalise particular understandings, which lead to regulation and control in society (Rose, 1996).

A phenomenological research approach might be allied with R. D. Laing's writings, in which it is suggested that therapists should connect with the people they help at a human to human level, or with Abraham Maslow's call to see the human potential in people. But the researcher cannot pick some ideas out as preferred means of understanding as these should be bracketed off. Humanistic and democratic ideas are gathered together here instead, to illustrate and summarise a range of human experiences which participants bring, so that this can then be considered alongside experiences described by other participants in following chapters.

Participants describe their experiences in which they expect that each individual person should make decisions based on their own will, even if this is opposed to the will of others. In these understandings, people would not be expected to invest their emotional energies in activities where they are not free to choose. Meanwhile the regulation of healthcare systems in modern western societies is influenced by Neoliberal politics, so notions of consumerism and choice in a market economy are also perhaps influencing expectations. However, again these means of making sense of experience can be understood as narrow interpretations which are promoted in particular cultural locations. They are perhaps modernist projects (Lyotard, 1984), incomplete forms of understanding which are used to maintain an established social order.

Many of the mental health workers who contribute to following chapters do not experience decision-making in mental healthcare as an expression of their personal will. When workers are not found to be making their own choices this can be confusing for participants in this chapter. Mira, for example, feels that she is

encountering a system rather than a person. When decisions are made in a systematic manner, they can be experienced as lacking creativity, as inhuman and stifling. Mira and Olivia hope for more personally meaningful and spiritual means of managing emotional distress. They speak about patients who receive psychiatric treatment as somehow unable to grow. Like a 'mouse in a laboratory,' these people are not in control and cannot even say no to the treatment; they cannot make choices based on their own emotional disposition.

It is strange that in contrast to expectations expressed here, it is observed in following chapters that workers rarely feel that they are in control of decision-making processes and they do not find themselves able to attend to their own feelings or follow their own desires; although they do describe a significant degree of emotional engagement in their work. Meanwhile in this chapter, John and Olivia describe how their choices as lower grade workers are limited, as they must work with interpretations which are imposed on them by more senior workers, a case of 'we decide and you do it' (Cott, 1997). Participants often find themselves engaging in 'thrown projects with situated freedoms' (Heidegger, 1962). An existentialist position would emphasise the lack of an essential self, questioning the assumption that there is a pre-existing person who could act on their own individual desires or follow a predetermined plan (Sartre, 1969). Emotions would therefore have an unsettling quality, a response to the uncertainties of life (Kierkegaard, 1859/1956). While a person's feelings will be troubling, Mira and Olivia in this chapter think of them as healthy, so that psychiatric medication is seen as inappropriately numbing or preventing their natural process (Stevenson & Knudsen, 2008); while the action of denying people this aspect of their experience is thought to be inhuman. In contrast to this, in the next chapter,

experiences of emotions are explored where they are found to be untrustworthy, or somehow unwanted.

Although they emphasise the importance of individual choice, a sense of emotional connection or interpersonal trust is important for participants in this chapter. John and Olivia suggest, for example, that it is only possible to know a person well enough, so as to make judgements about the causes of their behaviour, when an emotional engagement develops through a number of encounters. Also, there is a sense in which some participants cannot feel emotionally connected with workers, who appear to them to be hiding behind policies and procedures, ‘letting the system be their boss,’ or ‘making judgements based on just one meeting.’ As reported in other phenomenological enquiries, family members who provide informal support or care often feel excluded (Wilkinson & McAndrew, 2008). They are often left out of decision-making processes, but perhaps this is related to the expectations and assumptions they bring, as revealed in this chapter.

Humanistic, democratic and consumerist ideas are traced in the assumptions participants express, while they also refer to different knowledge systems or ideologies such, as the ‘medical model’ and ‘recovery philosophy.’ From the accounts that are given here, senior workers can exercise control by promoting one or another of these forms of understanding. People who provide informal care, or are employed to provide support, are not then able to influence decisions or question the understandings on which they are grounded. It might be expected however, that senior medically qualified workers would always impose a biomedical interpretation and other unqualified parties might try to promote a recovery philosophy, which is largely

founded on humanistic beliefs (Leamy, et al., 2011). However, Naomi who is a family carer, seeks a biological interpretation in conflict with a psychiatrist, who continues to promote a more social, psychological and humanistic means of making sense of her daughter's behaviour.

This chapter attends to an individually grounded experience of decision-making, where it is expected that an internal emotional disposition should drive each person's choices, associated with humanistic notions of personal expression and growth. A person's choices can then be made sense of as a part of their rationale, their particular approach to life, as steps in a journey they choose to take. These are aspects of the experience of being human which extend into most of the following analysis chapters. Experiences of this nature include the expectation that mutually agreed decisions cannot be negotiated unless relationships are founded on an equal ability to exercise power; that without this power, or control, a person will not invest emotionally. Also, there is this suggested dynamic, in which people exercise power by promoting particular interpretations, in which their interests are favoured. This challenging experience of alternative interpretations is something which arises in all the analysis chapters.

The next chapter will move on to examine decision-making at a more interpersonal level, where emotions are not experienced as stable aspects of a person's individual disposition, so that the influence of trust and shared responsibilities can be observed in more depth. This will enable an examination of the more mutually constructed aspects of decision-making, in which paradoxically, the experience of personal growth or self-discovery, might actually tie people into processes of self-regulation.

The possibility can then be explored that we live in a society in which some people are free to experience and act on their emotions, while others are not. This suggests inequalities are mediated by particular interpretations which lend agency to some people more than others, so that neo-liberal and humanistic philosophies are not serving all our shared human interests.

Chapter 5: In the driving seat: experiencing mood disorder

Introduction

This chapter introduces experiences of decision-making as encountered when participants are struggling due to their fluctuating moods. Accounts are given by Anna, Frank and Peter, who all have a diagnosis of mood disorder and take psychiatric medication to help them manage their emotional states. They do, however, have diverse experiences and their accounts are not brought together as if they represent a category of person, or to make claims about the influence of their diagnosed condition. It is intended instead that particular experiences of making decisions are revealed, which might to some degree be shared by anyone. Brief introductions for these participants are provided below. It is the nature of their fluctuating moods and the processes of making decisions in complex relationships which are examined here.

Anna is White British in her late twenties. She developed emotional difficulties and accepted a voluntary admission to psychiatric hospital. She is now diagnosed as suffering from bi-polar disorder. She lives with her partner and is supported by community mental health services.

Frank is White British in his sixties. He struggled most of his life due to an excessive use of alcohol and in more recent years is diagnosed with bi-polar disorder. He was recently admitted for a period in a psychiatric hospital.

Peter is White British and in his fifties. He was treated over the past ten years for recurrent depression. He believes that he had originally suffered from post traumatic stress disorder which was not diagnosed and was left untreated.

Thematic summaries

Trusting decisions; trusting people:

Participants are struggling with fluctuating moods and they depend on others. Trust is a central concern in this groundless sense of being. Participants can feel they are devalued by imposed understandings. A sense of shamefulness is associated with an inability to make consistent decisions

Time and distance in making decisions:

It is difficult to making decisions in the moment. Participants try to gain a perspective or a sense of distance. The influence of others might be containing or intrusive. Often, when they make decisions based on their feelings, or on the advice of others, these turn out to be flawed choices or choices which they do not want.

Responsibility and self-regulation:

Experiences of losing control are described. However, participants are brought into a position of regulating their emotions, while feeling under pressure to exercise control is not the same as exercising freedoms. But in the absence of a reliable sense of self, consistency in making choices is brought about through interpersonal encounters.

1. Trusting decisions; trusting people

The experiences described in this chapter draw out the manner in which choices are situated, in lives that are influenced by challenging events and occurrences, linked with the experience of dramatically fluctuating moods. These events and feelings are beyond the control of the individual person. Trust then comes to the fore as a central concern, where participants struggle to feel that they are making reliable decisions, so the ability trust the advice and support of others is important. Various strategies are described by which participants might feel that their choices are not being influenced by their changing moods. There is the option of asking other people to monitor them and tell them if they are concerned, or simply accepting the advice and opinions of others with the hope that things will come right through good fortune. However, these interactions can also be experienced as an intrusive loss of control. Then, when it is already difficult to make decisions, the interpretations which other people bring can feel particularly uncomfortable, associated with shame and a devalued social identity.

Peter talks about the value of having someone he can trust, someone who will hear what he needs, who will tell him when they are concerned. In his account of suffering from depression, he raises the question of whether he can trust his own decisions. He describes how he approaches people asking for help:

I think it is all the aspects of trust. Whether you know that person, whether you have a relationship with them, whether you respect them, whether you, whether they'll understand where you are coming from if you are going to make a decision that, um. I know certainly that when I've um been to somebody, I I've have told them what I

need; "Here's where I am here's what I most likely need, if you see me slipping tell me." (Peter: 408-416).

For Peter trust develops when there is time for respect and understanding to become established in his relationships. He depends on others, in ongoing relationships, to make him aware when he suffers from depression and he is keen to know if his decisions are influenced by this emotional condition. This concern about 'slipping' is related to situations when he might waver, doubting his ability to make good choices. At work he is a part of a team and he uses this to gauge his performance, so that he notices if he makes decisions which are out of step with those of other team members:

If I don't, check with the team how I am functioning then I could, I could fall over, I could, I could take steps back. It's very important for me to be open and honest with somebody. Just be able to say; "Here's how it is, here's how my decision making processes are. If you've got any concerns you need to be telling me up front." (Peter: 195-199).

Certainly for me, for me if I am depressed, if I am well, decisions are about trust. Can you trust your decision, if you can't trust your decision, who can you trust to talk about that decision? ... I think it is being able to trust somebody enough, which is to me is, is the greatest aid to decisions, because it is very containing, knowing that if you're, if you're not performing, somebody can tell you (Peter: 402-422).

If Peter is open and honest, he will be supported and colleagues will let him know if his decisions cause them concern. This suggests a kind of interdependence and,

whether his mood is low or not, decisions are strongly connected with this notion of trust in his relationships. As discussed below, a depressed mood can cause someone to feel overwhelmed and unable to make decisions. Because of this, Peter tries to gain a sense of containment, so as to be held in a place in which he can experience himself as a competent decision-maker. Peter needs other people to help him identify the influence of his varying emotions, which he cannot trust, and this enables him to feel in control.

Frank also experiences difficulties with decisions and, like Peter, he is able to trust others. He reflects on his admission to a psychiatric hospital and expresses his view that people in this situation are in the hands of others:

I think you're in the hands of other people, and you put your trust, or you hope you're in the right hands and the person will do the right things for you, because I think well I don't know can't think for others but I know I was ignorant (Frank: 503-506)

How would I know, what would be the best choice, myself, personally because I'm not educated, so I have to rely on that educated person as far as the drugs are concerned (Frank: 552-554).

Frank hopes that he is in the right hands and that mental health workers will do the right thing for him, because he does not have the required knowledge. He does not accept or refuse medication based on what he wants, or how he feels, because he cannot know what would be the best choice for him. Frank does not feel competent as

a decision-maker but, he finds that he is fortunate when the choices workers make please him and fit with him:

I was fortunate that the choices that were made for me, um, pleased me and fitted in with me, but um, I don't really know, why um... If I didn't agree with them I would have said something (Frank: 38-42).

I get choice and that, I have that choice, yes, um, well I, like I say I keep saying it I feel that I'm one of the lucky ones (Frank: 821-822).

Frank was pleased with the choices that workers made about his care and treatment, so that in trusting them and uncritically accepting help, a clear route forward in his life opened up for him; *"I was fortunate... that things fell into place there."* (Frank: 167-171). Frank explains that many of the other people he meets, who also suffer from bi-polar disorder; *"Don't seem to have gone down the same fortunate road that I went down that everything has been put in place for them."* (Frank: 150-151). Frank feels therefore that trusting others helps to smooth the way for him, so that his needs are met. There is however, for Frank, more of a sense of random good fortune, rather than an active attempt to make good choices, or any sense of being in control. Frank often feels lucky and although he also talks about distressing experiences in his working career, he does not feel this does him any harm, he describes a time when he was employed as a nursing assistant in a psychiatric hospital:

I didn't agree with their, some of the things that went on in the hospital... It gave me an experience which, in some ways I don't know what they thought they were doing

but it done me good, hasn't done me any harm, as far gaining experiences with other people is concerned (Frank: 112-117).

Frank did not agree with some of the things workers were doing and he describes distressing and abusive practices. He reports that he was alienated by colleagues because he would not go along with these bad practices. He does not however highlight his refusal to collude as a decision he made and he speaks more of events as if they just happened. Good or bad experiences are for Frank often chance occurrences, rather than outcomes he brought about, or difficulties which he would need to manage. His experience of trusting people, putting himself in their hands, is also connected with this idea that experiences do him no harm.

In contrast, Anna is not pleased when she accepts the decisions of others and she finds her choices are in conflict with those of family members. She describes a decision which is particularly important for her, when she ended up buying a house which she did not like, because she listened to other people:

[I] was quite often led by their decisions rather than my own decisions, over what I wanted and what I liked um and ended up actually buying a house that I didn't like, though listening to other people... I just listened and, listened to them, and because their opinions are normally worth quite a lot, and I respect their opinions that, I, followed their advice, rather than have my own decision (Anna: 56-65).

Anna is trying to distinguish between decisions which are hers and those which are made by others. It is possible that she would gain a sense of herself as making her own choices, when others oppose her will, but is a precarious position for her,

because she also feels that her choices can be the wrong decisions. Anna feels that most of her decisions are influenced by others, especially her mother who *“Always thinks that she, she is right and if I make a wrong decision she always lets me know that it was wrong and I should have done it her way.”* (Anna: 85-88).

Anna’s experience is different from that of Frank and Peter. Although in Peter’s account, it is clear that his decisions are influenced by other people, he still feels that they are his choices and, like Frank, he is pleased or content with the outcome of these decisions. Peter describes how he actively uses other people to check his own decision-making. Being a member of a team provides an external benchmark against which to measure his choices:

Because there are for me, there are, there are benchmarks to my functioning which, which helps me know where I am, from a decision making point, point of view. The other important thing from a work context is to have a team, um, unless you can see your decision-making processes reflected off of other people... you can’t be as sure, you can’t be as comfortable with yourself and your working (Peter: 153-161).

And for me the key to making decision is about this interdependence, if it is there and you’re comfortable and you’re feeling contained you can make decisions, you can throw them out in, in the ether. People can look at them openly, you can get solid responses to them, it helps, it, it um, it externalises your own reality check (Peter: 441-445).

Peter's experience of containment when making decisions, is achieved when he sees his processes 'reflected off other people;' he is then in control rather than 'falling over or taking steps back.' With this support he feels comfortable in himself and his work. The trust he has in others enables him to feel that they help him make decisions which are connected with an external reality, but still grounded in his own choice.

In contrast, although Anna also struggles to trust her own choices, she is not able to get 'solid responses' from others. This is then a different experience from that of Peter, who is more able to accept help in identifying the influence of a depressed mood. But then again, like Peter, Anna is aware that changes in her mood can influence the choices she makes. She explains how she will decide to go back to bed when her mood is low. At these times she cannot decide whether to make a cup of tea or not, or what to eat. In contrast, when she is in an elated mood, she describes herself as making decisions all over the place:

If I'm low in mood I find making any, decision, really difficult, um, I don't have the energy, or, or the frame of mind, to be able to make, make a decision even if that is making a cup of tea or, um trying to deciding what to eat, then the decision is, is almost too difficult to, to make and I end up going back, back to bed and not achieve anything just my safe place, my safe place is, is deciding to go back to bed but if I am high then I can make decision all over the place, um, and they will be quite rushed and hurried rather than um, thought about and carefully planned, um, so I will end up getting into more trouble, um, I will spend money, a lot, quicker, than I would if I was in a stable mood (Anna: 229-237).

When she is in a low mood, Anna does not have the energy to make decisions. She ends up going back to bed; her one choice is to make herself safe. Peter also struggles to make choices when his mood is low; *“When you are depressed, sometimes being asked if you, whether want sugar in your tea is like being asked about the existence of God.”* (Peter: 122-124). Anna explains how her experience of a high mood is different. Her decisions at these times feel rushed and hurried, rather than thought about and carefully planned. Her impulsivity at these times is experienced as a problem rather than a freedom.

Like Anna, Peter and Frank describe their changing moods and they rely on other people to gain a sense of containment or direction in life, when acting impulsivity would cause difficulties. But Anna feels at odds with her dependence on others. She does not believe that the choices which she allows others to make for her, such as purchasing a house, are right. She also discusses an arrangement, agreed with her partner, in which he is invited to contact mental health services when he is concerned about Anna’s emotional state:

I, didn’t like it to start with because I thought it was someone going straight over my head, and was telling tales, on me, Um, I felt as though they had they had to keep a constant watch, and were waiting for any hiccough... Everyone’s allowed a down day, or a happy day, and it’s not just because I am unwell it’s just that I’m having I’m having a rotten day like the rest of the population and I don’t want anyone to jump too quickly, into thinking oh she’s relapsed or she’s, doing something that she shouldn’t be doing (Anna: 333-343).

Anna was not comfortable with the idea that her partner could contact mental health services and she felt as if she was being watched, as if they were waiting for any minor problem, such as a slightly inappropriate decision. Anna then makes the observation that everyone, whether they have mental health problems or not, will have difficult days. She is made uncomfortable by the possibility that her withdrawal and her ordinary mistakes, or even her happiness, might be interpreted as signs of illness, or some kind of bad behaviour. So it must be even more difficult for Anna to trust her own decisions when she feels that other people around her do not trust her and that they are watching her.

Anna describes herself as someone for whom decision-making is always difficult; *“I have flipped many a coin [laughs].”* (Anna: 175) and now she has the added problem that she is thought of as mentally ill; her moods are ‘too high’ or ‘too low.’ She does not always find these interpretations are helpful for her and she would prefer to be understood as just having a rotten day like anyone else.

In contrast to Anna’s experience, Peter observes that *“You might be the last person to know that you are not particularly well.”* (Peter: 20). Peter says he values the choice he made to be open and honest about his problems, a choice which he feels he made in a conscious and thought out manner:

I think that as a mental health worker that’s, a conscious decision to be open about it um, personally it has proved quite valuable to me. I think that is has been part of my recovery is to be able to be open about it and carry on working (Peter: 528- 532).

Peter shares his difficulties with immediate colleagues in an open, honest and trusting manner. He describes this as an aspect of his recovery, which is perhaps an investment in activities which help him to overcome difficulties. In contrast to this, Anna struggles with the experience of trusting workers:

I do accept, that sometimes somebody else has, needs to take responsibility for me, if I am unwell, not that I feel like that when I am unwell, but I only feel like that when I'm, [laughs] when I'm well (Anna: 344-347).

Anna can sometimes accept that because she struggles to make decisions she needs someone to take responsibility. Then, when she is in a different emotional state, she does not see any need for workers to be involved and again, when her mood changes, she views the latter mistrustful emotional state as a form of being unwell. Her laughter suggests that she feels embarrassed by her inconsistency. In one moment she feels she can be responsible for the choices she makes, believing that she is entitled to be 'just having a rotten day,' then at a another time, she is aware that her choices are inconsistent and somehow not her own, so that others must intervene. It is difficult to see a preformed essential self in Anna's experiences when the nature of her being is so open to change.

The experiences of struggling to trust one's own decisions and then trying to trust the advice of others are complex. Each participant describes their individual response to the dilemmas they face in these circumstances. They express varying views as to where responsibilities lie in mutual decision-making processes. Where advice is taken, it is still possible to experience an important decision as the wrong choice, as

something a person would not decide independently of others. But in contrast, it is possible to just feel fortunate when receiving guidance from others, to rely on happenstance in the hope that things will come right. When a pragmatic and emotionally disengaged stance is taken, it is possible to feel that difficult experiences actually cause no harm. Alternatively making an effort to build and maintain trusting relationships, might enable a sense of control to develop. Making routine decisions in a context where people share responsibilities might be experienced as supportive.

2. Time and distance in making decisions

This section turns to experiences of time and distance in making decisions. These aspects of existence often mediate decision-making processes, as if people are experiencing their choices differently in the immediacy of the moment and then from the perspective of hindsight. The notion that they might gain some distance from a decision, so as to see the dilemma more clearly, comes to the fore as another important aspect of human experience.

Perhaps the material described above, related to trusting or distrusting other people, represents an aspect of this core experience, when participants are trying to gain some kind of emotional or psychological space, so as to make their own choices. There are difficulties again in achieving trust, although a reliance on others seems unavoidable. Time and distance combine in these experiences and participants sometimes withdraw into themselves, when there are no opportunities open to them.

Anna reports that she needed time out and that going away on holiday was good for her mental health. But also, this was a decision she made against the advice of others.

Distance and time are important for her in helping her to feel that her decisions are her own:

I needed time, time out, and everybody was saying to me that I had to stay and for finance financial reasons and that going on holiday was too expensive but I thought that for my mental health, that, going way was actually far greater advantage, than, coming back and being a little tight on cash so the decision was for my, own health (Anna: 106-110).

The physical distance of being away on holiday gave Anna a sense of interpersonal separation, enabling her to follow her own reasoning rather than that of others. Her need for time and distance appears again in the experience of changing moods and her dilemma as to when to seek help from a mental health worker. Anna does not want to go immediately to discuss these mood changes. She prefers to wait a few days to see what will happen:

I'm getting better at phoning earlier, I still like, I still like to take, time I do leave it a day or at least a day or two to see whether or not things settle down on their own (Anna: 219-220).

Anna feels she is more able to seek help from workers in a prompt manner. There is again a sense that she wants to feel in control, making her own choices. She is drawing a contrast between this sense of wanting to be in control in the moment and the recognition that, when choices are observed with hindsight, they are somehow not what she would want:

They were choices my choices because I was in the driving seat of whatever I was doing at the time, but, they were quite often the wrong, the wrong choices once, I could, look at it from, a bit further away, um, they were, they were, too, too rushed it was, I wanted something instantaneously and therefore I'd go and get it (Anna: 250-254).

Although Anna describes herself as ‘in the driving seat,’ she also feels her decisions were too rushed. She now believes that she acted in the moment to get what she wanted. It is difficult, however, for her to read a rational account of this back into her behaviour. So although they were her choices, they were also somehow the wrong decisions. She observes that at the time she had; *“No concept that it's a wrong decision you think it is the right thing to do at that moment.”* (Anna: 269-270). Anna's experience, in which she sees her decisions from a distance and then feels that they were the wrong choices, is a central concern for her.

Peter described a similar experience in the development of his mental health problems. He has not always experienced trusting relationships and in a previous job, he did not trust his managers:

The decision to get help or whether to tell your manager, um, is fraught with dangers, your manager, reports to his manager, his manager reports to another manager, if there is cause for concern, this, this escalates and ultimately can affect your employment (Peter: 53-56).

Certainly, um, my second episode, my employers at that time there saw it as a sign of weakness, um, and, I consider, that they made efforts to con, constructively dismiss me, um, ineffective efforts, unfruitful on their part, um but certainly they made efforts to, move me out of the organisation (Peter: 79-83).

Peter feels that his decisions were fraught with danger; he was concerned that if he decided to get help or talk to his manager, a cause for concern might be raised in the organisation, which could threaten the security of his employment. Being honest about how he felt would only give his managers more ground on which to claim that he was weak and perhaps they would then argue that he could not do his job. Peter also describes how he could not trust a GP and, like Anna, he is evaluating his experiences using hindsight. He accepted treatment for depression but now believes that he needed psychological therapy:

I recognise that I have had an episode of PTSD, um but that was very much after the event once I um looked at the presentation with some distance from it (Peter: 78-79).

Peter can now look back at a difficult period of his life and make more sense of it. He feels that he needed psychological therapy to help him overcome Post Traumatic Stress Disorder and without it he developed a recurrent depression. However, at the time he struggled to know what to do and his options appeared to him to be limited. He does not believe that an adequate solution was possible:

You need to choose the least wrong option. I don't ever feel that there is a right option, I find myself choosing the option that feels the least wrong decision, there are going to be flaws in that decision (Peter: 54-56)

Peter finds himself choosing options, like Anna, which are somehow wrong. Then, when he had taken his concerns to his G.P., he reports that he was not offered psychotherapy; *"I have never been offered any psychological, back up, from the G.P.s."* (Peter: 29-30). He goes on to explain that in his professional understanding, psychological therapies should be offered promptly in the treatment of Post Traumatic Stress Disorder. However, he was not able to use his expertise as a mental health nurse and feels that he was put under pressure to accept nothing more than antidepressants:

I know that the best interventions for PTSD are psychological interventions so I certainly felt railroaded then into just taking an antidepressant (Peter: 210-212).

Although he has specialist knowledge, Peter felt that he had no choice but to take medication. It is strange that he does not benefit from his professional expertise and he just accepts the prescription of antidepressants without challenging his GP. His reticence is explained when Peter emphasises the term 'involvement,' suggesting a need for partnership:

I'd stress the word on the involvement, involvement meaning that there is some type of partnership where one party knows how they feel and the other party perhaps knows how to treat (Peter: 316-319).

Peter wants a partnership with his G.P. in which he can give an account of what is going on for him, while the G.P. decides how he should be treated. Peter explains that he is cautious about making the decision to engage in psychotherapy. He is concerned that if he spoke about his problems in therapy he would lose his sense of a cohesive self; *"If I was, was to just delve into things about my life and my past, I am concerned that I might fall to pieces."* (352-353). As described above, Peter values the containment he feels when other people give him honest opinions on his decision-making, but he does not feel contained in this encounter with this G.P. He would like to make a decision about engaging in psychotherapy in which his G.P. shares responsibility, but he does not trust himself or the G.P. Peter, then, does not feel that there is a right decision; some choices are not really a choice and taking antidepressants was the 'least wrong option.' But even if he thinks he is making a good choice, like Anna, that decision can be found to be inadequate when viewed with hindsight:

You may think you know best but your decisions, when viewed from a distance, may be fundamentally flawed (Peter: 315-316).

There is conflict in Peter's experience between decisions made in the moment and the evaluation of these choices from a distance. This is again a core experience where Peter does not feel he is supported in important relationships.

Frank also describes an experience in which his effort to share difficulties is rebutted. Frank wanted to offload problems and he would not mind if they were shared. He views this sharing and solving of his problems as a part of the role his worker is employed to fulfil:

He said; "Well look, I can't, I'll have to share that... with my colleagues." And I thought well, I wouldn't have minded if he would have shared it with his colleagues in some ways, because it was something I wanted to, offload, you know, um when I look back on things I think well, maybe that was part and parcel of his job (Frank: 643-648).

Frank would prefer this worker to hear his account and share responsibility for what he did, or what he should do now. Frank is not confident about his ability to make decisions about his life or his relationships. In contrast to the experience of gaining a distance from decisions, as described by Peter and Anna, when Frank was admitted to psychiatric hospital, he found himself taken up in the routine of the ward; *"Just go and collect your tablets at a certain time of day, you know and, that was given to you that you would go and get your tablets."* (Frank: 469-470). Frank does not recall making an active decision or considering whether he was free to leave hospital or refuse treatment, for example:

I didn't know, if it was free or didn't care because I was getting help, in some ways, with what was happening, that, to be truthful um, probably was it might have been explained to me, that when I went in, or, I was in there, saw by a doctor or whatever, um, I don't recall (Frank: 392-395).

Frank was not concerned about this status in the hospital in the sense of whether he was detained or not, what his rights or freedoms were and if these matters were explained to him, he does not recall. He felt he could protest against decisions, although he did not want to; *"I just didn't challenge anything you know let's put it*

that way; to see if I did; that freedom of choice.” (Frank: 431-433). His experience was that he felt he had choice and freedom; he just did not need to take space to formulate his own decisions and instead he had withdrawn into himself:

I was very withdrawn and very sort of quiet, quite withdrawn something, and um, it was a new experience for me because I'd never been through it before, the room was comfortable (Frank: 77-79).

Frank observes that he was withdrawn and then refers to the admission as a new experience. But also, he felt helped and supported, rather than finding solutions of his own. Individual autonomy is not, therefore, a significant aspect of Frank's experience. Instead, he has a similar experience to that of Peter, who feels contained when gaining honest feedback on his decisions. Frank feels contained by the admission to hospital, where his decisions would be made by others and he feels comfortable with himself.

Like Peter, who did not challenge his G.P.'s prescription of antidepressants, Frank does not challenge the decisions of workers at the psychiatric hospital. It is interesting, therefore, that when Frank talks about his life he does not describe himself as seeking opportunities in an active sense but observes that options were not put there for him. He talks about a choice of jobs, in the sense that he could walk out on one job and easily get another, but he did not experience this as a real choice, because he just went and got any job:

Choices weren't there and, you know, then when it came to sort of working in factories you were sort of, I was sat on this conveyor belt watching, bread go by, you

know I wanted to do other things, I did escape, I did you know I mean, at that same time I'm whingeing about it but at the same time I'm I um, you can pack up one job, and get another job in some ways, in the restaurant business, I used to be quite confident I could get another job (Frank: 787-792).

The jobs which Frank took on were not leading anywhere. He was sitting by a factory conveyor belt watching bread go by, then, working in hotels as a trainee manager or waiter. While Frank is generally positive, willing to accept support and forward thinking, he also feels that his life has not turned out the way he wanted it to. When it comes to his education, for example, Frank feels that; *"The opportunities and the choice weren't there."* (Frank: 770-771). So Frank might wonder if the decisions he make are right for him, given the reality he faces, that if he had gained a good education, things would be different. Since Frank does not feel he is living the life which he could, he struggles to know what the right choices are for him. When he is asked to account for the decisions he makes, like Anna and Peter, he finds it is difficult to describe a rational plan behind his choices.

Participants seek a sense of perspective on their choices and the advice or interventions of others cannot always be trusted. When they look back at their decisions, these choices appear flawed or somehow wrong. They find themselves in a place in life which is not where they would choose to be. It is not easy, therefore, to see how they might make rational choices based on a preformed plan and concerns are expressed that examining past experience might bring about feelings of falling apart. It is difficult to give a rational account of inconsistent decisions in a world where not everyone is trustworthy. These participants do not now have the opportunity to get

back to where they would have wanted to be. They feel perhaps that they are somehow at a distance from their own lives.

3. Responsibility and self-regulation

Although there are many differences, participants are facing the same existential dilemmas. They are all struggling to make decisions in difficult interpersonal encounters with others, in the moment, while also looking back and feeling unable to account for the choices they made in the past. They are aware of their changing emotions and the inconsistencies in their preferences or priorities. However, they are finding ways to manage, trusting others so that their needs are met, checking their decision-making processes with others who are concerned about them or tolerating the intrusion of others. It is not clear however, whether these interpersonal processes are granting them more freedom, or tying them more firmly into commitments within which they must regulate their moods. This last section explores this question, observing how a loss of choice is somehow transformed into taking control. Being autonomous in regulating one's own moods is perhaps an internalisation of social pressures, rather than an expression of personal freedom.

Frank is positive in his attitude and he feels that challenging experiences are good for him. In talking about the time when he worked in a psychiatric hospital he felt the difficulties he encountered did him no harm. Then when talking about being admitted to psychiatric hospital himself; *"I was going by what other people, were doing for me, and it all seemed for the good."* (Frank: 426-427). So when Frank expresses a sense of fortune or luck, as in the notion of having gone down a fortunate road, he places the randomness of life experiences to the fore. He is playing down the possibility that

his own choices might be important. If Frank is not confident in his own decision-making, assuming that solutions to his problems are 'in the hands of others,' he must be open to the hope that everything will come right by chance. This is not, however, the entirety of Frank's experience and although he feels he was not given opportunities, he believes that he has; "*Done quite alright, as I've seen it, in some ways.*" (Frank: 230-231). He does experience himself as making decisions:

I did have choices when it comes down to, I've given up drinking lately, um, I'm sorry in some ways that I took the choices, of having a drink (Frank: 285-286).

Frank clearly holds himself to be responsible for problems he experienced in relation to his use of alcohol, but he also speaks about an experience of abuse in his childhood and expresses the notion that he should move on in life and not linger:

I had some experiences when I was young, that um, I've discussed with the psychiatrist, I um, the um, I think I'd have been a different person if these things wouldn't have happened to me, I was abused when I was young. I know that's been said many times before, um, but I don't know, you have to move on, not linger onto them sort of things (Frank: 201-207).

Frank's experience of random events and fortune are, no doubt, linked with all aspects of his life, but he specifically mentions sexual abuse in his childhood. He expresses the view that he would be a different person if not for this thing that happened to him. This is a fundamental experience of choice or options being taken away, so his life is

not always experienced as his own. He feels that being ‘in the hands of others’ provides a greater sense of consistency or security than following his own impulses.

Meanwhile, although Anna’s experiences are different from Frank’s, she also gives an account of choices being taken away, or options not being there for her. She draws a contrast between consulting a mortgage adviser and seeing a psychiatrist. She felt able to make decisions in a structured manner when choosing a mortgage, when she took advice and weighed pros and cons. Then in contrast to this, it did not feel like she was consulting an expert in choosing medication; *“It was pretty much there this is the medication this is the tablet that you are going to be on.”* (Anna: 157-158). While Frank welcomes the manner in which his psychiatrist takes responsibility for prescribing and managing medication, Anna wanted to be more involved in these processes. She mentions a hospital admission, which she feels was imposed on her:

I when I was very first, ill, I, um when I was admitted to hospital, I was sat in a room and I was saying that I didn’t want to go into hospital, that I wanted to go home, and I was threatened with, um, Mental Health Act, saying that if I didn’t come into hospital, then I would be forced to come into hospital... And that scared me enough, to make the decision that OK I would come into hospital as a voluntary patient, but I felt that all my decisions, any decisions that I wanted to make that I wanted to go home had been taken away from me (Anna: 506-515).

Anna recalls that she was sitting in a room and she wanted to go home. So unlike Frank, she did not want to go to hospital and she felt threatened. She was told that if she did not accept the admission, she would be detained under mental health law and

admitted anyway. She felt scared so she decided to go in to hospital, although she says that all her choices were taken from her:

It was, enough to be, um, threatened with, with having all your rights taken away from me, and being forcibly controlled into doing what they want you to do, was enough for me to say OK I'll I'll come quietly (Anna: 528-531).

It is interesting that Anna speaks about this admission as a choice she took when she felt threatened and scared, as at no point did she have a choice, because she would be detained anyway. This ambiguity is problematic for her, and this is a similar experience to that of Frank, where choices are taken away. But in contrast to Frank's willing acceptance of treatment, Anna feels she was persuaded to take medication and she also mentions a decision she made some time later, to stop taking it:

I was persuaded by my, um, mental health workers that I needed to take, medication, um, and I started taking medication and then I stopped taking medication and I relapsed quite badly, and, so that decision, I I made the decision that I wanted to come off the medication cause I thought I could deal with it on my own, on my own terms (Anna: 120-124).

Anna feels that she was persuaded to take medication and she then stopped taking it, having the belief that she could deal with her difficulties on her own. She felt there was a chance that she would not need it and she wanted to take that chance. She clearly believes that this was her risk to take and that while, with hindsight, she now

believes that workers had made the ‘right decision,’ she felt that she could choose at that point not to follow advice:

I wanted to take that chance, that risk, and, it was they were in the end their advice and their decision to put me on mediation was the right the right, right decision (Anna: 126-128).

This sense of ownership is consistent with a purposeful form of self-determination. Her action of ‘trying things out for herself’ is of her own choosing, while previously she had felt that she was being guided by workers:

I felt it was very much, I was very much guided by what, what they were saying, rather than imputing my own ideas, because I felt that they were the experts and they knew what they were doing (Anna: 295-298).

No matter how many times I was told that we are not here to push you in any direction I always thought of as, as, workers as an authority figure and they are there to tell you what to do and what you can do and what you can't to do (Anna: 468-470).

In her first contacts with mental health workers, Anna felt that they were the experts and she found herself being guided rather than putting her own ideas forward. She experienced workers as authority figures and she expected them to push her in one direction or another. But she then responded in a manner which could be thought of as taking control, making her own decision:

I just did it and I told somebody about four five weeks in that I wasn't taking my medication any more, and the response was I can't condone what you are doing, because I think you should be on medication, but, you have to find out for yourself. So, she kept the ball firmly in my court, um, even though she she said she should be taking medication (Anna: 486-489).

Anna made an autonomous choice, a decision to stop taking medication, and she did not tell anyone. When she did share this with a worker, Anna was also told that she would need to 'find out for herself.' So Anna felt that her decision to stop the treatment was respected, it was treated as a rational attempt to test this option out, to see what happened. Anna could then be held to be responsible for her choice and she gains more of a sense that further decisions about medication were her own:

I have got to know the service much better um, that I know that I'm, autonomous. Um, I can make my own decisions, and I don't have to rely on somebody one else to help me make that decision (Anna: 471-473).

I could put forward, any objections or ideas, um, because I knew the service a bit better, and also I knew the mental health worker a lot better, um, and felt that I could put forward ideas rather, than just sitting back and taking it (Anna: 300-303).

Having got to know the service and her worker better, Anna now feels that she is autonomous and can make her own decisions. She describes her interactions with workers as more of a partnership in which she can express her thoughts and she can disagree. Having established this more trusting interactive relationship Anna no

longer feels she is passively accepting the decisions that are made about her treatment. She expresses the view that she is more informed and more able to manage her problems herself:

I knew what was more available, to me, and that, I that was also beginning to know my own mood cycle and, that I could, um much easily um, converse, with, with, how I was feeling rather than um, letting the mental health worker, look at me and then assess me from that way, I was then able to open up and talk, more freely about how I was, how I was feeling (Anna: 320-325).

Anna got to know what was available to her in mental health services and she was beginning to know the cycle of her moods. In her previous experience, she let workers look at her and decide what to do, but with her new forms of understanding, she is able to ‘converse with how she feels.’ This is a kind of self-regulation, a self monitoring of her emotional state and she is taking active responsibility for managing her behaviour; *“I like to take, to try to take control of my own mood rather than people take control over me.”* (Anna: 221-223). She also describes her use of a ‘sleep and mood diary,’ an aid to her self-monitoring.

Anna’s decision to stop taking medication, along with the response of a worker who told her that she would need to ‘find out for herself,’ had brought her into a position of responsibility. She is learning about patterns and cycles in her life, using this to predict and manage changes in her mood. This is a form of self-regulation in which she must give up some of her freedom and separation from others. She has perhaps met the biological limits of her freedom and it is required that she accept regulation so

as to contain her feelings; *"I tend not to make any decisions in the morning."* (Anna: 280). She is not then free to act impulsively based on her emotional disposition, but becomes responsible for ensuring the stability of her feelings.

Peter, like Anna, also discusses regulation as he asks whether he should continue to take psychiatric medication or not. He faces a difficulty in recognising the influence of his moods, saying there are days when he knows he needs to take his medication and days when *"I wonder if there is anything wrong with me."* (304-304). He is faces a dilemma in holding responsibility for maintaining the stability of his moods.

There is a paradox in this notion of self-monitoring, as a sense of control emerges from experiences in which control or choices are taken away, along with ideas about choices being 'wrong' or 'flawed.' Peter knew he needed psychotherapy, but this was not offered, so that he did not feel he had a choice; but he chose to take antidepressant medication instead, which is the 'least wrong option.' But it is Anna who expresses this transition most clearly as she moves, from having no choice other than accepting admission to hospital, to trying sometime later to manage without medication, then 'finding out for herself' that she needs it.

Different understandings of Anna's behaviour are influential. It is not thought that she could make safe decisions, due to the effects of a disease process, so she was removed to hospital. But Anna felt that she could be in control, making her own decisions. A doubt remains, however, as to just how much choice participants actually experience. For example, although Peter says he values the structure which work affords him and he chooses to be open and honest about his depression, this is not really a choice:

I think that if the team feels, you're, in some way not being open and honest about it, then I think that there is a tendency to exclude (Peter: 552-553).

When thinking about the difficulties that his depressed mood can cause, Peter feels under pressure to be honest with team colleagues, as he might be excluded if he is not. He speaks about choosing, but this is again perhaps a 'least wrong' option. Like Anna's struggle to feel she is making her own decisions, how much can it be said that Peter is making free and independent choices when he depends on his colleagues to give him confidence in making decisions?

There are similar experiences here, where participants are concerned about being excluded or not being given opportunities, so that making the same choices as colleagues, or choosing one dead end job over another are not actually free or independent decisions. Similarly, being offered a voluntary admission to psychiatric hospital, when the only alternative is to be detained and taken there anyway, is not much of a choice. The loss of control in these paradoxical social interactions is clearly distressing. However, these processes can pull them into self-regulation, so that they must choose to use psychiatric medication to manage their moods, avoid excessive use of alcohol, only make decisions in the afternoons or otherwise regulate their lives.

Participants can experience other people as experts who know better than them what the right choices should be. Then, while these decisions are sometimes also the wrong choice, or the least wrong option, they are now somehow their own choices. There is paradox in these accounts, where a transition occurs, from experiences of having no choice, to achieving a kind of emotional self-regulation and thereby becoming

responsible for taking treatment so as to manage moods in a kind of internalisation of external pressures.

Conclusion

Participants in this chapter occupy ambiguous positions in complex interpersonal processes. While they are held in these processes, there is a sense of groundlessness in their experiences of making decisions, in which emotions cannot be trusted. Although they make decisions which appear to them at the time to be connected with their desires and feelings, sometime later they find that their emotional disposition changes and these choices no longer make sense for them. In response to this, rather than founding their decisions on their own will, participants are caught up in interpersonal pressures, accepting the opinions and advice of others. But problems are still unresolved as people cannot always be trusted.

Decisions are often difficult because, as Peter describes, none of the options feel right, or choices are limited so that a flawed decision must be taken. This can then raise questions about the degree to which a choice can be understood as authentic, as Jean-Paul Sartre might ask (Sartre, 1969). Regretting the manner in which one followed the advice of others, as Anna describes, is not the same as investing one's own emotional commitment in a decision-making process. While on the other hand, being pleased with the options others choose for you, as Frank describes, is not the same as taking responsibility for those choices (Cohn, 1997). However distressing experiences such as Post Traumatic Stress Disorder and childhood sexual abuse are mentioned, so perhaps it would be difficult for participants to know how their lives would be, if these distressing interruptions had not occurred. Subsequent experiences of losing

control might therefore have a more poignant resonance for them and they might wonder how they should make choices when they are not living the lives which they would be, if those distressing intrusions had not impinged on them.

In the accounts given in this chapter, emotions are not simply experienced as driving choices. In their attempts to be rational self-determining individuals, participants talk about their feelings as somehow unwanted, as intruding or sabotaging. So further questions arise; for example, how much can it be expected that people should always be in control, when some experiences in life, such as childhood abuse, are clearly intrusions which they would not chose to endure? If they were not able to control what happened to them, how can they feel responsible for the situations in which they now find themselves, or make plans to take control of their future? This sense of withdrawal or ambivalence suggests that the notions of personal growth and freedom discussed in the previous chapter might not be meaningful for everyone.

The previous chapter began with the account given by Olivia (Chapter 4 pp. 102), who decided to separate from her husband. She described this as an impulsive decision, but if problems arose as a consequence, she believed that this should not concern others as she would be responsible. However, it is possible that, like the participants in this chapter, Olivia might find that she cannot control subsequent events as much as she would like. Then when looking back, she might experience her choice as flawed, or somehow the wrong decision. In a world in which it is not always possible to be in control, the notions of personal growth and freedom might be questioned (Beauvoir, 1997). It is possible that everyone struggles to maintain consistent feelings on which to ground their decisions. But participants who are

diagnosed with a mood disorder feel that they face exceptional difficulties when facing choices, so that it is required that their emotional responses are contained or managed through their interpersonal relationships and through the use of psychiatric medication.

Participants in this chapter do find their own means of managing the difficulties they encounter. Different approaches include the strategy of conducting relationships in a trusting and open manner; requiring that other people are honest in their dealings, so that a responsibility for making appropriate decisions is shared. Alternatively, as Frank describes, a person might just put themselves in the hands of others. If he feels that he has no control or choice in life, he might withdraw into himself so that others take responsibility for him. However, from Anna's experience, having others take responsibility can clearly feel intrusive, as if rights and choices are being taken away.

Different interpretations can be applied when people struggle to make consistent decisions and this mediates expectations about who should hold responsibility. When it is thought that participants do not have the capacity to make decisions, for example, workers take control and hold responsibility for ensuring needs are met and risks are managed. But where Anna reports that her difficulties are ordinary and commonplace, she resists the claim that her behaviours are symptoms of illness. The meanings attributed to behaviours, such as symptoms or rational choices, are considered again in the next chapter, where mental health workers describe how these conflicting interpretations also create difficulties for them.

Disturbed emotions can be accounted for by reference to traumatic or abusive intrusions. But participants then find that they are expected to be responsible for their situation, although they have not chosen to be where they are in life. They might therefore feel ashamed when they are not able to make consistent choices; they are not 'the person they would want to be.' While people who are disabled might feel ashamed if they are somehow physically incomplete, people who suffer mental health problems face a 'moral shame', a shame at not being accepted as a completely reasonable person (Sayce, 2000). Also, being in a 'mentally incomplete' state requires that they rely on others to help them make choices. However, shame is a common emotional experience, often expressed within interpersonal processes. People can for example feel powerless in relationships, when they believe that unless they are accepted by others, then they are not complete (Leeming & Boyle, 2013). Then, when they face choices on their own, people feel overwhelmed; an experience observed in other phenomenological studies of mood disorder (Rhodes & Smith, 2010).

The accounts given in this chapter suggest that responsibilities can become attached or detached through interpersonal processes, where different interpretations are promoted. While Frank finds himself 'in the hands of others,' so that he holds no responsibility; Anna follows the advice of others, so that it is not then her fault when she purchases a house which she does not like, for example. Holding responsibility can be uncomfortable and everyone sometimes finds that their freedom to choose is just too open, prompting complex emotions. Following the advice of others or accepting a diagnosis of mental illness might therefore be interpreted as an inauthentic response to existence, in the sense that an immediate individual engagement with one's own life is avoided (Sartre, 2001). However a strong sense of interpersonal

connection is expressed by participants in this chapter. In whatever manner their problems are understood, there is a need to trust other people in everyday processes of interdependence and this is perhaps unavoidable, an issue which is explored in Chapter 8. Perhaps interdependence is an essential human experience and the only means by which people can give their lives meaning or gain a sense that they are not alone in facing difficult dilemmas (Merleau-Ponty, 1962).

Experiences of life can be so random, intrusive or complex, that at times participants in this chapter do not think of themselves as particularly good at making choices. Life can then be experienced as uncontrolled, with a loss of any sense of self, experiences which are observed in phenomenological accounts of fluctuating emotions (Inder, et al., 2008; Rusner, et al., 2009; Crowe, et al., 2012). From this chaos, however, a sense of an individual rational decider can be brought about, as processes of self-regulation are promoted. Where psychiatric medication is used to manage moods a person can achieve a sense of distance or separation from others, an experience in which they do not feel so overwhelmed. Teal (2009) for example, describes how people use antidepressants to block out their feelings, when they find that other people are too emotionally intrusive. Phenomenological enquiry provides an understanding of problems such as depression as rooted in the interpersonal emotional flow of relationships (Granek, 2006). The nature of a person; as well or ill; as competent in making choices or not; as responsible or not, is often constructed in these interpersonal encounters, or otherwise read back into the meanings attached to the person.

It is possible that participants might be manoeuvred though the ideology of 'empowerment,' as promoted within mental health services (Rose, 1996). Are they encouraged, for example, to self-regulate so that they no longer need expensive hospital admissions or regular community visits? The interventions of mental healthcare are not returning participants to the lives which they would choose or enabling them to make sense of the contradictory emotions they feel. Workers are not always willing to engage in an interpersonal emotional connection in a human to human relationship, as R. D. Laing might encourage (Laing 1967). These participants are not therefore able to trust some workers, so that their needs are not met. They then face further dilemmas as they find themselves responsible for regulating their moods through the use of psychiatric medication. They must decide whether these treatments are working or not and how long they should continue to take them (Inder, et al., 2010). This self-regulation is not then experienced as a form of freedom.

In the next chapter the need to regulate emotions is raised again when the accounts that workers give are examined. These workers also experience a need to deal with their emotions, as they try to experience themselves as active decision-makers within the bureaucratic regulation of their employed roles. Decisions are again found to be complex and interpersonal, where different interpretations of rights, responsibilities and capacity are influential. Differences are noted however. Where participants in this chapter speak about their position as either engaging in decisions or not, participants in the next chapter talk about being pulled along in a flow of decision-making processes, having little control over the manner in which these events are interpreted.

Chapter 6: Getting them on board: front-line practitioners

Introduction

This chapter builds on the accounts given in previous two chapters and introduces Emma, Greta and Ian. They are all employed to assess people who need help; to provide therapeutic interventions in community mental health services. Some background information is provided in the box below and they are brought together here so that their experiences of making decisions as frontline qualified members of staff can be explored.

Emma is White British and in her late twenties. She is an occupational therapist working with people who suffer enduring mental health problems, having been attached to a rehabilitation hospital and then working in a community team. Emma helps people to regain or develop skills so that they are able to live more independently in the community

Greta speaks with an Australian accent and is in her forties. She is a registered mental health nurse. She worked in a number of hospital based mental healthcare settings. She is newly employed in a community mental health team where she assesses and supports people who need ongoing care and treatment.

Ian is White British and about thirty years old. He worked in several skilled and semi-skilled jobs, before training to become a registered

mental health nurse. He subsequently worked in several mental healthcare settings and currently within a community team. He attempts to engage and treat people in the community when they fail to engage with services.

Thematic summaries

Stepping in and out of a professional role:

Decisions outside of an employed role are free-flowing and impulsive. However at work, participants must make structured decisions, while feeling pulled between the needs of the people seeking their help and the targets of their organisation. However, can they still experience creativity in a rebellious subversion of their bureaucratic systems.

Stuck in the middle:

Workers try to hold people emotionally while helping them learn and grow. But they might be attributed with a positive or negative emotional disposition or narrative identity and they can experience feelings of shame. There is an alarming sense of groundlessness.

Facing ideological dilemmas:

Decisions are given conflicting meanings when problems are thought to operate at biological, psychological or social levels. Participants are required to choose whether they should be active in taking decisions in their own right, or passive in accepting the influence and interpretations of others.

1. Stepping in and out of a professional role

Participants in this chapter all draw contrasts between their experiences of decision-making at work and in their home lives. Outside of their work roles, they can be less organised and more impulsive, although they do feel their decisions are influenced by others in both settings. Work is more structured and they all describe a need for creativity, although this is difficult for them to achieve. Participants talk about decisions as processes they engage in with others. They might be made at home, for example, as a part of a family network and then, at work, as a part of a community team; so that choices are not totally free or individual in either setting. However, participants are resisting the regulating processes of formal decision making and they talk about stepping in and out of different roles or giving the appearance that they are different kinds of people. They are experiencing a sense of their own agency by seeking creative solutions to complex problems. In meeting different agendas, they are willing to be unpopular with senior colleagues, prioritising the needs of the people they are trying to help.

Outside of his professional role, Ian feels he can be impulsive, as illustrated by his decision to purchase a car. This is based on how he feels at the time and on what he thinks he needs, rather than a rational exploration of the advantages or disadvantages of a particular model:

I'm told, that I'm quite impulsive, when it comes to, a car is a great example, I I see a car, I think yep that one meets my needs, I want it, and then I think, I don't I wont sign on the dotted line, but I'll make that in my head, the decision's made, and then, my

wife, ****, will sort of look at the wider picture, and sort of bring me back down to earth (Ian: 174-178).

Ian recognises his impulsivity and is aware that he relies on his wife to contain his decision-making, to show him the wider picture and bringing him back down to earth. The decision to purchase is then based on the family's financial situation, along with the practical realities of running the car.

Greta also describes how she makes decisions in her home life and draws a contrast with her experiences at work. At home she goes with the flow and can be a little bit chaotic, but she uses terms such as 'scaffolding,' 'focused' and 'logical,' to describe her experience of being at work:

Working I'm much more scaffolded, and very focused but, in my personal life, because I don't need to be, I'm not so, I tend to go with the flow, a lot more and perhaps try something rather than think logically about it, so there might be a little bit of chaos about me when I'm not at work, um, which is quite strange really (Greta: 181-185).

At home, she is aware that her decision-making can be based on poor information and she revises her plans when gaining more experience; "*Sometimes you might have to dip your toe in it, so see whether it's a good thing.*" (Greta: 155-156). Greta likes to try things out rather than sticking rigidly with a plan. She discusses a plan she formed, to take up a different employment role, when she suddenly changed her mind. She experiences herself as starting more things than she finishes:

I've changed my mind last minute, so in my mind, I have this idea of what I would be, but until I went and heard, gained more information, had discussions about it, spoke to other people about it, it appears I had more of an informed decision more experiential um, um, view on it, or take on it, um, so I guess, what that says about me is I probably don't react, take time to think about things um, and the danger of that is that I might be a bit of a starter and not a finisher [laughs] (Greta: 130-135).

Greta is discussing how she is disorganised, she tries different things and changes her mind, but this is acceptable at home; while at work she must be organised; *"I'm more conscious of the impact it would have on people around me whereas at home, I'm accepted for who I am."* (Greta: 199-201). But even at home Greta feels uncomfortable if she is suddenly seen as lacking organisation. She laughs when talking about being a 'starter rather than a finisher,' suggesting a degree of embarrassment. She talks about leaving papers about on her kitchen table, feeling that this is alright, but unexpected visitors cause her to panic:

So my decisions would be in response to an external stimulus, like a door bell, unexpected person's turned up even if it's my family, and I wouldn't want to be seen as not being contained and um, probably inappropriately, it doesn't happen very often but when it does [laughs] a panic bell goes and I suppose that's the, um, the decision making, in the sense that something is making me do something differently, even though I was quite happy to be sitting you know with with papers around me (Greta: 224-230).

Greta is expressing a dilemma here in the sense that she feels happy sitting with chaos around her, but that sudden sound of the doorbell is an intrusion which might cause her to make different choices about how she lives. So would she choose to be organised, or is she responding to the pressure of others? She says wanting to be seen as 'contained,' is probably inappropriate, as if she should be self-motivated and true to herself rather than basing her choices on how she is perceived by others. She feels she should be more assertive in her own living space, expressing her own emotional will, rather than managing her appearance.

Emma also recognises a degree of disorganisation in her decision-making. She refers to her own experience of mental health problems as inspiring her to help people at a practical level, while feeling that becoming an occupational therapist (OT) happened for her by chance, rather than as something she planned:

I think, that my own personal experience of, mental health, um, is what inspired me to, um, to w, to work on on on the real practical levels of life, I mean OT was something I kind of fell into by mistake, but I don't think working in mental health was, and, um, yeah I think that is, that kind of, um, encouraging the person to have the best possible life that they can have, regardless of what the illness is (Emma: 520-525).

Emma fell into becoming an occupational therapist by mistake and because of this, she cannot then expect that the people she is trying to help should be more organised. She is instead encouraging them and working on practical issues, while suggesting that their difficulties should not limit their potential; as her problems had not prevented her from gaining a professional role. However, this is not easy and she

discusses the difficulties she has in agreeing decisions, reflecting on problems she encounters. In seeking an explanation for these difficulties she refers to institutionalism, as imposing roles, in which people can exercise different degrees of power. She suggests that a power dynamic between therapist and client cannot be avoided:

Maybe it's just the institutionalism of it all, or I think there is a power dynamic, which you can't avoid, with the therapy, therapist and the client, and I think that happens, sometimes, even though you are trying to, get them on an equal setting, fundamentally they're aware of it, you're aware of it (Emma: 100-104).

Emma is trying to get the people she is helping to make decisions with her on an equal footing, but feels that both parties have a fundamental awareness of a difference in access to power. In her employed role Emma finds she is working to overcome this difference; *"I think there's a, with clients there's a feeling of us and them, sometimes, um, so, to try to engage with them, more, so that they don't feel, belittled."* (Emma: 591-594). She is worried about the way her expertise as a worker is experienced by the people she is trying to help. She has knowledge and qualifications, which might cause people to feel that she is more able, or entitled, in processes of shared decision-making. Some ingenuity is required to overcome this difficulty and Emma is aware that she changes who she is at work so as to achieve certain tasks, such as engaging people who occupy different social positions from her own. She is exercising a kind of creativity as she tries to appear in a different manner from how she knows herself, simplifying the words she uses;

Sometimes I'll, um, change my, um, personality, a little bit, to kind of to, or not use words that would be, too complicated for them (Emma: 591-592).

Greta also talks about the strategies she uses so that people experience her as more like them, rather than as a mental health nurse who holds expert knowledge:

You have to draw upon your own life experience, you have to disclose examples of that, sometimes, appropriately, in order to, enable somebody to think 'well actually yes she does know a little bit of how I've been feeling,' rather than have this blanket; "Well I'm a professional and I know best." It's more a case of saying; "No, there's days I don't have great days, I think that's a little bit of how you feel today, and I've got a little bit of understanding." (Greta: 1026-1032).

Greta feels able to share some aspects of her personal difficulties, so as to gain the confidence of people who seek help. She is trying to help people feel that they are involved in mutual agreements. People feel more in control if they believe that they are supported in making decisions by someone who has similar experiences and understandings to their own, rather than someone who employs remote or expert knowledge. Participants are, therefore, setting their expertise aside to stand as an equal with the people they help. However, Emma talks about the awareness that there is always going to be a 'power dynamic.' She also observes the manner in which the agendas of her employing organisation are different from those of the people she serves. She feels that her strategies for gaining agreements might be manipulative:

There's, often, difficulties, and trying to get, service users to agree, sometimes I think sometimes we're being manipulative, to get the clients to come on side with us, to what we think is right, more than, rather than what they think is right for them, because of the targets we have to adhere to as well (Emma: 30-33).

Emma is not entirely comfortable in her employed role, as this separates her from the people who are referred to mental health services, while there are many experiences which they share. She would prefer to get 'on side' with them, to help them, rather than manipulate them into processes which serve the interests of her employing organisation.

Emma and Greta are both able to experience themselves in different ways as they step in and out of their professional roles. These roles can be a hindrance; part of an uncomfortable and imposed structure. They are trying to serve conflicting agendas, so that they must change the nature of their own being, to achieve outcomes. Ian also struggles with the structure of his work routines, where he spends time travelling between appointments and cannot always write down his priorities. He reflects on possible options as he drives and feels caught up in the commitments he makes; trying to make decisions about one thing while he travels to fulfil agreements he made elsewhere:

You spend a lot of time in the car, driving between places, and I find that I'd think of something that's a really, positive thing or really negative thing regarding a particular decision, and if I don't write it down, I'll I'll forget it, but it's quite relevant so I'll write a list, of for and against, um, if I have time (Ian: 213-215).

While Ian is travelling between appointments he is thinking about decisions in which he is involved and is struggling to record, recall or organise these thoughts. Ian moves on to talk about creativity, suggesting that many of the difficulties he is trying to resolve do not fit with what most people would expect. He experiences a need to adapt ways of working for individuals who do not conform:

It's about being creative, it's about thinking outside the box, it's about coming up with new ways of working that meet the client's needs... the clients that don't conform with the world (Ian: 623-624).

Ian gives an example of his creativity when he talks about finding a form of respite for someone he is helping. He is trying to help this person to live in the community and he arranges for a period of care in a home which would provide a break from the challenges of day to day life. Ian explains that this person depends on his mother who provides practical and emotional support. But this means that she is unable to take a holiday, as no one else would be available to meet her son's needs. Ian arranged for care to be purchased from a residential unit and this was not a standard form of care arrangement:

I had to argue actually this was um, respite, it just happened to be in a residential unit because, there are there are no other provisions for respite, that were available, so this wasn't on that menu (Ian: 637-639).

Bureaucratic systems often require that resources are pre-defined and available as options to choose, from a menu. But Ian is willing to be unpopular by operating

outside of this system, so as to deliver a better service. He is pleased, therefore, to be helping this man's mother to have a holiday, while respite is provided in an unusual manner. But Ian had not make himself popular with senior colleagues who would prefer that he should follow the standard procedures; *"His mum's enjoying a holiday courtesy of care break money, um, but it, I can't say my name was very popular in the funding panel [laughs]."* (Ian: 648-649). Ian is celebrating the unusual challenges he faces in his role, using the metaphor of not fitting in a box:

Well we don't apply for the normal things do we, we apply for, strange things that that don't fit in a box (Ian: 654-655).

Ian experiences himself and the people he is helping as not fitting within the spaces available within the logic of healthcare systems and this gives him a sense of himself as an agent, as a rebel, finding strange and creative solutions, working against a pressure to conform. This is an encounter with a difficult reality by which Ian can test and stretch his creativity.

Greta is having a similar experience, trying to find ways to describe her work which are not lost in repetitive and undefined plans; plans which are just left behind in files:

So unless you're particularly good and focused and, kind of thinking outside of the box, the care plans to me, are a bit prescriptive, repetitive not very measurable, and often stay, in someone's notes, particularly in secondary recovery teams, unchanged (Greta: 41-44).

Greta observes that, in the team in which she recently started work, care plans can be repetitive, prescriptive and un-measurable. Records are completed more often to serve the needs of a bureaucratic system, than the needs of individual people who are seeking help. Workers who acquiesce to the bureaucracy just use stereotypical phrases in their documentation, because this is quicker than adapting their use of language to each new situation.

Participants in this chapter find it is difficult to hold on to a sense of who they are as individuals while taking up a work role. Organisational structures are imposed so that the expression of individuality might be denied to them. However, they experience themselves as creative when they make choices against the flow of these institutional processes. They express a belief that they can find ways of being which are creative enough, so as to function within the regulation of the institutional system, while also serving the people who need help in living their own lives, on their own terms.

These accounts reveal a contrast where, outside of work, choices can be somewhat impulsive, chaotic and unplanned, while being at work demands something more, an adaption to organisational pressures and diverse needs. However, compromise is needed in both settings, as decisions are negotiated with others. Participants also change who they are; making themselves meaningful for the people they are trying to help, with less concern for how this might look from the point of view of their senior colleagues.

2. Stuck in the middle

Participants in this chapter speak about the difficulty of expressing individual choice or creativity in an employment setting governed by systematic or regulated decision-making procedures. In this second theme, complex and contradictory expectations are noted. Although these workers are organised in teams, they are held to account as individual professional practitioners. They are required to facilitate decision-making processes in which different agents all feel they have a stake. But these workers are then required to sign documentation as if this were a decision they made by applying their individual professional knowledge or expertise. At the same time the documents are the property of the employing organisation, but the agreement (or care plan) belongs somehow to the person who is being served by the organisation. This is therefore already complex, but further difficulties arise due to differences in the ability to exercise power in hierarchical systems; while decisions can be fluid, with people changing their minds in an unpredictable manner.

Greta is trying to apply formal professional knowledge when she is helping or treating people who deliberately self-harm. She is expected to reduce or manage risk, but also to respect the rights and freedoms of others. She discusses the idea of responsibility and questions the degree to which it is reasonable to hold people to account for their choices and actions. She believes that some people who self-harm do not have the ability to manage their problems; they lack adequate knowledge, or have never coped with a particular difficulty before. Greta does not, therefore, always promote choice or involvement, believing that the provision of professional advice and support is safer:

I'm happy to encourage people to make choices, with support if they want that, I don't think it is good to say; "Well if you're self-harming you need to own that and take responsibility for that." Um, because people may not know how to, but what I could do is say; "It would be really good if you could manage that, what if we went and got some dressings, or what if you learnt how to cut in a place that wasn't particularly that harmful, but still gave you the same response." And I think that is very different, and I think sometimes people feel very dismissed; "And now suddenly I've got to cope with this when I've never had to cope with it before." Um so it has to be planned well so I think that's again the educational bit about decision making (Greta: 404-413).

Greta is concerned about the notion of abandonment. She worries that people feel dismissed when they are left to cope with difficulties on their own. She is not comfortable with this and draws a contrast between working closely with someone and leaving them to make their own choices. She rehearses the things she says to someone who self-harms through cutting, so as to reduce risk and she believes there can be too much choice; *"Choice is good, but there can be too much choice."* (Greta: 456). However she talks about education, suggesting that when a person is informed and they know how to manage their difficulties, they can then be held to account. Greta is therefore cautious about the use of new 'self-help' approaches, such as encouraging the use of a mood diary:

If you're having a session with somebody face to face, you can touch on more things, you can touch on painful things but you can also contain it for someone so that they feel psychologically safe and physically safe, whereas if you are telling somebody to

go into a mood diary, and they're writing all these things down, and it it conjures up thoughts that they can't deal with (Greta: 796-801).

Again, Greta feels uncomfortable with leaving people to manage their problems on their own. She describes interpersonal movement and contact; such as 'face to face' and 'touch on painful things.' In her view self-help activities are not safe and she talks about 'containment.' She experiences a desire to hold the person, to help them feel psychologically and physically safe. She feels she must gain the person's trust; entering into mutually agreed emotional contact with them, but in doing so, she becomes responsible for activities which she cannot control; she is not actually able to prevent the action of self-harming.

Ian has a similar experience as he tries to help someone who goes on to take an overdose of their prescribed medication. He is, like Greta, concerned about people being left to face risks on their own. The action of taking an overdose is another form of self-harm and Ian explains that this woman nearly died. Ian wants to prevent this kind of fatality, but he explains that the team in which he works could not agree an approach. He then felt 'stuck in the middle.' He describes how senior professionals and influential staff have different agendas. In the midst of this conflict, Ian was required to agree a plan with the woman, when she told him that she felt unable to control her feelings:

I had to deal with, her presentation, my my feelings as care coordinator, but also the team agenda and there were various team, agendas within the team, I was getting pressure from above, from senior practitioners to really change things, um, and that

was supported by a couple of others, influential staff who... had a very set agenda how her care should be implemented, then there was other team members who, who had a different agenda who felt that, this person's care wasn't being put first, by the other people and it was a, interpersonal thing within the team, and I kind of felt myself, felt myself stuck in the middle of all of this (Ian: 237-245).

Ian describes difficult pressures and expectations, experiencing a complex dispute in which various parties have different agendas. Although mental healthcare is often provided through a team approach, in Ian's experience, he is expected to mediate as an individual. It is required that he finds a rational solution which all parties can accept and it is clear that he is not making a choice based on his own emotional disposition.

Ian mentions his feelings in the same sense as he talks about other pressures or problems he is dealing with. These feelings are connected with the responsibility he holds and are expressed in his doubts as to whether the woman he is trying to help is able to take responsibility for maintaining her own safety. Ian decides to take an empowering approach, promoting the woman's autonomy and supporting her in working towards the recovery of her mental health. He asks her to maintain responsibility for managing her medication, based on his professional judgement that she has the ability to do so. However this ability is then subsequently brought into question, due to the woman's action of taking an overdose:

I was on a visit with this person, she was expressing suicidal ideation, um, I assessed that, her level of intent was particularly, low to medium but that, but she had

protective factors in place, um, she was having a meeting with a friend later, she was going to be talking to her daughter, she'd made plans for the days following, but she asked me to take hold of her medication and I said; "No I want you to to maintain responsibility for this." But anyway she took a massive overdose, and ended up in the medical assessment unit (Ian: 249-256).

Ian feels caught up and pulled about by pressures and expectations. He makes a judgement about this woman's capacity and her intent which is then shown to be dramatically incorrect. In requiring that she maintain responsibility for her own medication, Ian is seen to promote her freedom and respect her right to self-determination. But it is likely that the action of taking an overdose would be seen as a sign of mental illness rather than a personal choice. So Ian is criticised for failing to identify this risk and for failing to treat the illness which, it would be presumed, caused that risk. Ian experiences shame in response to this perceived understanding of him as failing to meet adequate professional standards. Then, even though it appeared that this woman had not managed to take responsibility, Ian's colleagues wanted to reduce the amount of support she received. His more senior colleagues made decisions, even writing a care plan while Ian was on leave, requiring that he should inform the woman on his return to work:

I went on holiday, and when I came back, the members of the team that had quite a set agenda that this person's care should be, withdrawn in some ways and, reduced, and, we should be much more kind of hardboiled, had rewritten her care plan, but left if for me to go and tell her (Ian: 256-259).

Ian's colleagues wanted to take a more 'hardboiled' approach, with less emotional involvement, expecting that this woman would be capable of taking on more responsibility. Unlike Greta's experience of forging a close and supportive relationship with someone who harms themselves, Ian is required to step back and he was concerned that he might be abandoning this woman. His colleagues understood him to be emotionally 'over involved.' As Ian gives this account, there is a form of paradox in his expression; "*I had to make a decision.*" (Ian: 263). This is not an experience of freedom, or an exercise of power, but a kind of pressure he could not resist. However, Ian felt able to take his concerns to the woman who took an overdose. He still believed that she could take on responsibility and he wanted her to have ownership of the plan:

I had to make this decision, do I go with it, and take it to this person, or to take elements in it that I agree with, but rewrite the elements that I don't agree with, and in the end I took it to the client as a; "These are suggestions from the team, this is a blank template lets work on, what you want, what I feel will be helpful, and lets work on what the team feels will be helpful, but lets ensure that you have ownership of your care plan." (Ian: 263-268).

Ian is experiencing a difficult encounter with people who have conflicting agendas, finding himself in a position in which he must take action. He paraphrases the words he used in approaching this woman, re-living his position as a kind of go-between. He talks about a form of interpersonal pressure acting on him when he wonders if he should "*Stand up.*" (Ian: 278). Should he stand up because it is his name which is formally attached to a decision, as he signs the documentation? If this woman took

another overdose and died, it would be Ian who must give a rational account of his decisions in court, appearing before the Coroner, and he could lose his professional registration.

In Ian's understanding, he is making a formal recording of mutually agreed decisions, a care plan, which he believes belongs to the person he is trying to help. He explains that he wants people to take ownership of their care plan, so they can be supported in implementing it. But Ian is also managing the expectations of his employers, meeting targets, along with the conflicting opinions of his professional colleagues. He asks if he is going to be influenced in his decision-making and if so, by whom:

I think it's the client's care plan, I want them to take ownership of it, so that they, they can implement it with the support of us. So I guess I work to the client's needs and try and incorporate the targets into that, if it's helpful for the client (Ian: 52-55).

It was quite a, difficult time, trying to, making decisions and, do I feel influenced, and who am I going to be influenced by? Or who; am I going to stand up and be this person's care coordinator, and say; "Well actually, it's my name on this." (Ian: 276-279).

In these excerpts, Ian describes a situation which was a difficult time for him, where his name appears in documentation and he believes therefore, that he was responsible for the recorded decisions. Ian wonders if he feels influenced, and if so, by whom. Sometimes decisions can be a bit slippery and Ian is aware that part of the purpose of formal documentation is to ensure choices are recorded and firmly attached to those

who decide. These processes are enabling Ian to experience and express himself. He is defined as a good or bad worker on the quality of the decisions he is thought to make. Also, his priority is to meet the needs of the people he is trying to help and he will incorporate the targets of his employing organisation, if it is helpful to them. But then again, Ian must also consider the opinions of his colleagues:

But in this case, there was no collective team decision it was a split, and I somehow had to, to find a way of appeasing everybody to get the team on board so that, the care plan could be consistently implemented (Ian: 300-302).

Ian is referring to colleagues who have not achieved a collective team decision and he has the task of drawing a consensus together and he must build trust. Perhaps Ian's colleagues do not trust the woman he is trying to help. They might be concerned that if this woman were granted more time and support, because she took an overdose, then she would learn that this is a means of getting what she wants from services. The risk of further overdoses would then be increased.

Participants in this chapter struggle to manage the information they gain in their encounters with people. Issues of capacity, choice and responsibility are given conflicting meanings by different workers. Ian finds that he is made more visible, being aware his name appears on documents.

Emma also works as a member of a team, where again there can be differences of opinion as to how people should be helped; *"I think there's been times when, yeah, the team have made a different decision to your own, to what your own perspective is,*

and you just have to, go along with it I guess.” (Emma: 704-706). Going along with the decision of the team might be difficult, when, like Ian, it is Emma’s professional competency which is placed in question if things go wrong. These issues also arose, suddenly, in the interview with Greta, which was interrupted by an administrator who had an urgent message. Greta reflected on the reasons why it was thought necessary that she should be told immediately about a risky situation:

Usually it would be something that has happened like the incident just now; “This person’s doing this, we just want you to know.” “Well does that mean that you want me to know so that I can take that decision away and do something about it?” Um, so I think, some sort of crisis might occur, that forces a change in decision making, um, sometimes we decide to do nothing; why is that? Um, like why did I decide not to get up and whizz out, with my cape on? (Greta: 700-704).

Greta uses irony in her reference to a narrative identity which might be imposed on her, as someone who gets up to whizz out with a cape on. There is an understanding of her role in which she is held to account for ensuring that an illness is treated and associated risks are resolved. Information was passed, therefore, in an urgent manner and although she decides not to act, she was informed and picked out as the ‘responsible clinician.’ She suggests that this information was passed to her so that those who previously held it would no longer feel responsible for interpreting it or acting on it. She wonders why sometimes, when a crisis occurs, workers decide to do nothing. Some of the responsibility might be pushed back by not rushing out to resolve problems; by letting other people worry for a while. But there is a tension

here, as in Ian's example of the woman who takes a massive overdose. Workers have a duty of care and often they must get up and whizz out to take action.

Participants who contribute to this chapter feel stuck in the middle, not always having a means of taking control of the decision-making processes in which they are involved. They struggle to impose their own professional judgements and are often expressing expertise alongside that of others, responding to challenges and changes as they are unfolding. But this ambiguity provides a means to be creative, as events are often unpredictable, so that a flexible or fluid response is needed. These participants experience a significant degree of uncertainty in their work; when they are trying to negotiate agreements between diverse groups of people; when they find that they are suddenly informed of urgent or risky events. Agreements are broken and there are disputes over what should be done. But paradoxically, the bureaucratic systems of this work environment require that participants account for choices which they, as individuals, are assumed to make, even when they feel they are only serving the agendas of others.

There is no sense that an individual emotional disposition is driving decision-making, other than in difficult experiences of shame and anxiety. Instead, there is a flow of emotional tension as different forms of information and varying interpretations come into play through complex encounters with others. The disposition or motivation behind decisions might be read back into events in sharply contrasting accounts. Are participants too caring or empowering when giving choices, or neglectful when not managing symptoms of an illness? Are they too controlling or prescriptive or emotionally over involved? The nature of their subjectivity and their emotional

disposition is experienced as constantly in question, never fully established but always open to revision in the light of unfolding events.

3. Facing ideological dilemmas

Participants in this chapter all describe contested decisions, as agreements are forged through the processes of different agendas coming together, in a kind of interpersonal pressure. They have their own emotional responses to these challenging situations, but these are just another problem to be managed. Their priority is that they should meet the expectations of others, gauging their emotional processes to understand the choices they make. They can then use this information to build consensus through shared understanding. However, where people are not clear about their intentions, or often change their minds, this lack of certainty means that information is interpreted in sharply contrasting ways.

Participants are operating in a system in which different ideological notions can be used to frame understandings. The person they are trying to help might be understood to be encountering difficulties at a biological, psychological and social level. Participants can be caught out by this as their actions might be seen in a positive light when illuminated by one of these means of understanding and negative in another. They then find they are questioned by colleagues as their professional practices can appear to be of a poor standard.

Emma is trying to help someone who does not clearly state what he wants and his passivity can be given different meanings. When this man expresses agreement, she is not sure that he really agrees to the arrangements she writes in his care plan; perhaps

he is deferring to her expertise. In Emma's experience, decisions can be fluid, as things shift and change. She might think that an agreement is reached, but she is aware that this man might just be placating her:

Things shift and change quite quickly, sometimes, um, I'm thinking of, a particular client, who, who's pattern is, um, being agreeable, and, um, and saying yes to things, to kind of, keep you quite, but he's agreed to something, but has he agreed to it? Because, um, and that has caused problems (Emma: 80-83).

We say people have to be clean and tidy to live in certain situations, um, he chooses not to, or is it the illness, being the negative symptoms of the schizophrenic that stop him from doing that, and you know, where is the choice there?... we come in with the, you know; "You need to self care." [laughs] and encourage that, and is that from him or is that from us? (Emma: 236-254).

Emma is questioning the origins of a decision; suggesting that it is the workers who are saying someone should be clean and tidy. This man agreed to follow good standards of cleanliness, but when he did not fulfil this agreement, she wonders if this was a choice he made, or a symptom of an illness from which he suffers. She struggles with this question, because, if she imposes hygiene and organisational standards on someone who would not choose to live that way, her actions would be oppressive. She would not be promoting the person's freedom to choose how he wants to live. But if that person could not choose because they were suffering from the 'negative symptoms of schizophrenia,' then Emma would feel neglectful for failing to support him in achieving an adequate standard of self-care.

Emma is caught in this dilemma and, because she is a mental health worker, it is expected that she should make a judgement as to whether this man is capable or not, whether he is making choices or not. This is then the same kind of dilemma as Ian describes above, where he thought that a woman was deciding not to take an overdose, but then her action in doing so is understood as caused by mental illness. These concrete decisions are not in Emma's experience, easy to bring about. She describes how difficult it is for her to know what this man wants:

He was on board with moving to a particular residential setting, he was in agreement of it but then, um, wasn't actually happy there, but that never got expressed to me, because he doesn't do kind of elaborate conversation (Emma: 225-228).

Emma thought they were in agreement, but he was not able to articulate his point of view. A problem remains for her, in the sense that the decision which they made, for him to live in a setting in which he must maintain standards of hygiene, subsequently seems to be more to do with Emma's choice, than his.

Greta also struggles with the dilemma over whether a person is capable of making decisions or not. A woman she is trying to help stops taking medication, but Greta does not agree to this choice. So she is rehearsing or anticipating the experience of negotiating with her. This is an experience in which she is not able to impose her own choice as a professional worker or employ her expertise. For Greta it is 'Hobson's choice,' but she wants to define the parameters of the decision, so just exactly what is chosen and by who is clear. Greta is willing to see this choice as an experiment which

the woman is conducting and this opens up the possibility that lessons can be learned from the consequences:

I'm thinking it is a bit of a Hobson's choice because they're, they're doing it regardless, they haven't discussed they've already made that decision, so if it's damaging the patient and, almost, well a self-experiment, well you know; "You've chosen to do this, you're experimenting with this, um whilst I think that is really good, I don't necessarily think it is the best way of doing it because you could maybe cut some out, or reduce them, but now you've done it we're going to have to go with it." So it's sort of being flexible as well, so not having a concrete decision that can't be challenged or changed, but looks at the best possible outcome, in a damage limitation way... There is this service user being an expert on their own illness, but me being an expert from a nursing point of view (Greta: 743-753).

Greta's experience of being excluded from this decision is prompting her to negotiate and she seeks flexibility, rather than a concrete decision which cannot be challenged. Greta tries to combine the woman's expertise in her experience of her illness, along with her own expertise as a nurse. She is rehearsing the words she might say and observing that she does not have a choice, but, by offering support she is trying to pull the decider back into a joint decision-making process:

So; "How can we work round that." and the emphasis again was on negotiation and highlighting the consequences of not taking it (Greta: 395-397).

There is a pressure to ensure people make an informed decision, or that they are party to a decision-making process. This is related to the kind of understandings, which participants anticipate, might be applied by others. Greta is suggesting that including people in decisions enables; *“A little bit of a different way of looking at it, putting a little bit of responsibility back.”* (Greta: 361-362). It is not acceptable for this woman to stop taking treatment on a whim. Greta feels a need to give an account of the decision-making process and to allocate responsibility.

Greta makes a distinction between different ideological models in mental healthcare. She describes a traditional approach, within which she believes it is assumed that mental illnesses cause risk and that the sufferer is therefore unable to cope, unable to make decisions. She observes that professional interventions or treatments would be required with or without the person’s agreement. But she also refers to recovery philosophy, in which she must give choices and respect rights, because people only overcome their mental health problems when they assert their own autonomy and achieve an adequate degree self-direction.

Emma talks about her attempts to get decisions made *“on an equal setting”* (Emma: 101) and within a recovery approach, everyone involved in a decision is understood as equal in their rights, in their ability to understand, in their commitment to the plan and their responsibilities within it. While in contrast to this, Greta explains that in a traditional medical model, the people who are involved are understood to have different degrees of knowledge, ability and responsibility. She refers to these contrasting views when she observes that helping someone is not entirely medical, not only about prescribing medication. There is also a psychological approach, which is

about empowering a person to enable them to make choices. The concept of self is relevant in Greta's view:

It's not all about medication, if you looked at the concept of self, actually physical medication is only part of, the treatment but at a psychological approach, empowering somebody to make choices and a decision is much more therapeutic than popping a tablet, so, but I know, how does that sit, with the traditional way of working? (Greta: 319-323).

Although Greta wants to enable psychological growth, by empowering, she also observes that a traditional interpretation is likely to be applied. She is concerned that her colleagues or people in authority might see the effects of a disease process in this scenario. This biomedical interpretation is supported by the clinical records, which refer to previous periods of detention under mental health law, suggesting this woman lacks an understanding of her mental health problems:

So the traditional response I guess would be alarms ringing, this lady has been detained in hospital under [Section] 3 for non-compliance with medication in the past, um, but the recovery bit of me, and I'm using that language cause it's kind of become part of my vocabulary at the moment, I'm trying to be much more focused around it, was about just exploring with her, her views about them. Because if I was to look at the care plan, it clearly says; "Monitor medication, check compliance, look for signs, break through symptoms." all those classic phrases, but doesn't say; "Actively listen, challenge, explore, respect, value." (Greta: 259-266).

This excerpt clarifies Greta's experience of a sharp distinction between a traditional approach and the more recently introduced recovery philosophy. Greta is facing the challenge of trying to change the way she works. She does not want to listen to the alarm bells which are ringing, a warning which requires that she facilitates admission to hospital and enforced treatment. She wants to deal with the person and not just treat the illness. She observes how the care plan is completed in a manner which emphasises the management of symptoms rather than engagement with the person. She goes on to explain that not taking medication is the only thing this woman feels she any control over:

So I said to her about the decision to stop taking medication, she said; "It is the only thing I can control." So we then talked about other areas in her life where she could control, so that, was quite a useful way of kind of listening and seeing her point of view and things, and to be fair, I thought it was completely rational (Greta: 289-292).

When Greta listens to this woman's decision-making process she finds it to be rational, so she feels a need to validate this woman's experience and acknowledge her as an acceptable and reasonable person. But this kind of engaging and negotiating with the person does not fit with traditional approaches. This is an uncomfortable experience for Greta in which she is not sure if she is supported by colleagues. She might be seen as colluding with someone who is not taking medication because they lack insight into the nature of their illness; *"But that doesn't sit within the medical model, so I will be challenged about that now."* (Greta: 314-315). Greta works as a member of a team and checks with colleagues to ensure that her decisions are in step

with theirs. Her engagement with this woman is therefore a problem for her, as she might be pulled into decisions which would be criticised by colleagues.

Ian also expresses a concern that the approach he takes might be questioned by his colleagues, when he sits down and talks to a man he is trying to help. This man uses illicit substances and some of Ian's colleagues took the view that this is a personal choice. If his use of substances were to cause this man to suffer mental distress, mental health services would have a more limited responsibility for managing his condition, as it would be a form of distress which he brought upon himself. However Ian believes that there might be an illness process influencing the decision to use substances. Is not only about enjoying their effects, but also about gaining relief from the experience of hearing voices:

There was a view from some people that, he he just chooses to, abuse drugs at any given opportunity but when you actually sit down and talk to the client, it's quite clear that he's looking for some relief, from his voices, and and that's the reason why he continues, he enjoys, don't get me wrong he does enjoy the effects of the drugs, but they also relieve (Ian: 463-467).

Um, but neither him or his family, ever think that anyone's responsible that other than himself, so, so in that sense that makes it quite bearable for professionals (Ian: 532-533).

There is an assumption that, because people who use illicit substances are capable of evading the regulating forces of society, they are therefore responsible for the choices

they make. People can be held to account for inducing symptoms of psychosis through their use of illicit substances. But Ian took the trouble to talk to this man, gaining an understanding of his struggle with distressing auditory hallucinations. Ian views these experiences as symptoms of illness and not just a social problem of illegal activity. However, Ian explains that helping this man is not a priority for his colleagues and if he continues to provide help, he might be seen as colluding with or supporting the use of illicit substances.

Helping people who engage in self-destructive behaviours, such as the excessive use of illicit substances, taking an overdose of prescribed medication, or self-harming by cutting, all raise difficult questions about choice, capacity and responsibility. Choosing to comply with treatment, or not, is another scenario in which understandings are disputed with contrasting understandings emerging in which people are seen as rational or irrational. Different understandings mediate the manner in which these choices are responded to in complex social processes. Reductive models underpin these contrasting interpretations, as people are believed to be suffering because of problems which impinge on them through biological, psychological or social processes.

Emotional regulation or containment is a thread which runs through the experiences participants describe. They feel questioned or challenged if they care too much about the people they are trying to help, or if they neglect to treat illnesses. These participants are not then making decisions which are based directly on their feelings, or their individual judgement. In their work roles, they seem instead to be held in a kind of institutional system in which emotional connections with others are regulated.

They manage their feelings so as to make professional decisions, which their more senior colleague can support. However they do still experience that dilemma, that choice as to whether they take up the nature of their existence as an individual decider based on their own volition, or whether they accept the interpretations others impose on them, remaining ambivalent and undefined in contradictory roles.

Conclusion

The participants contributing to this chapter take on employment in mental healthcare where their decisions are experienced as more structured than in their home lives. They describe how they try to work creatively so as to overcome the constraints of this structure. However in their attempts to help people they are not just making decisions as free individuals; although it appears that this is how these decisions are usually recorded in their bureaucratic systems. They are called into being by their own position as someone who can be held to account within those systems of institutional regulation; while the decisions for which they are held to be responsible actually emerge through interactions within groups of people. For example, they develop relationships with the people they help in which there is a shared understanding and trust, but they are then concerned that they might be pulled into decisions which are not supported by colleagues; they will be challenged.

Participants must ensure that decisions are ‘owned’ somehow by diverse agents who often have conflicting agendas. These experiences are reported in other phenomenological studies, such as that of Elstad & Hellzen (2010), in which it was found that in order to help and support people mental health workers must ‘really see the person and facilitate social contact.’ They could then experience their role as

liberating, but also felt that they were dealing with the expectations and attitudes of other healthcare professionals.

The unsettling feeling of not being in control is a routine experience for participants. Their emotional responses to this are just one more thing which they must deal with and manage, rather than a basis on which they might formulate their own choices. They find themselves caught up in different interpretations, in which their actions are understood in sharply contrasting narratives. They face 'ideological dilemmas' (Billig, et al., 1988), in which they must serve people who are seeking help, promoting their rights and freedoms, while also managing risks which are caused by illness; applying their professional knowledge. This is clearly difficult.

As Emma describes, workers are trying to forge relationships built on trust, to understand people sufficiently so as to make judgements and thereby promote their professional interpretations. This is challenging for them when people ask for help but are engaging in behaviours which are self-destructive, such as self-harm through cutting, overdose, use of illicit substances or self-neglect. These behaviours can prompt feelings of rejection (Hadfield, et al., 2009). But participants in this study try to engage with people as equals, to sometimes step outside of the roles and procedures that are imposed by the institutional systems in which they are employed.

Phenomenological studies observe the manner in which workers might 'show a more human side of themselves' (Addis & Gamble, 2004). As suggested by participants in Chapter 4, this might be a more human form of contact. But this ambiguity could also be seen as an inconsistency or inauthentic expression of self. Existential theorists

might recommend that rather than taking on a pre-determined understanding of self or narrative identity, people find out about themselves through their encounters with each other (Laing, 1967). However, Ian for example, finds himself in a regulated institutional system, facing a difficult choice as he wonders if he should stand up to recognise his existence in that bureaucratic decision-making processes, or just allow himself to be swept along in the flow of meanings which others attach to him.

Due to the bureaucratic nature of their decision-making systems, participants in this chapter can find themselves operating as a kind of decision-making point or object within a rational logical system. There is then a desire for an experience of personal agency in a creative or rebellious approach to their work, so as to express their humanity. Or there is a sense of shame when they find they are unable to make rational decisions in a reliable manner. With no recognition of their individual freedom, or flawed humanity, they might experience a sense of being out of control, unreal and carried along by events, caught by contradictory expectations. This idea that people feel overwhelmed by emotionally demanding work tasks, experiencing an inability to exercise control, is addressed in psychological theory. Concepts such as ‘burn out’ (Martin & Schinke, 1998) and ‘depersonalisation’ (Sierra & Berrios, 2000) are used and these phenomena are conceptualised as abnormal mental and emotional states, which affect particular individuals (Onyett, 2011; Ward & Cowman, 2007). However, in phenomenological analysis, it is suggested that in describing experiences of depersonalisation, people are knowingly using popular metaphors to give their particular existence meaning (Radovic & Radovic, 2002).

Experiences are mediated by different meanings or interpretations in community mental health teams (Donnison, et al., 2009). There is a clash of ideologies, in which participants feel that negative or positive social value is attached to their being. They find conflicting but fleeting subjectivities are imposed on them, such as 'professional' or 'unprofessional;' 'caring' or 'uncaring;' 'burnt out,' or 'emotionally containing.' An attempt to capture this complexity should not therefore impose an interpretation in which simple distinctions between burnt-out or healthy are accepted as permanent or stable forms of being. Although for some workers this kind of stigma might become an entrenched identity, the assumption that these experiences can be measured objectively, is unhelpful. A complex social dynamic would be frozen, holding everyone within just one form of meaning.

When people are overwhelmed by complexity, the use of an understandable model might be favoured and Greta expects that her colleagues will defer to a traditional or medical model. Difficult emotions would then be understood as symptoms of illness, rather than experienced as an interpersonal connection, or something meaningful within relationships. The use of these models is not then a simple expression of academic or clinical debate; it is not the case that participants might take up or put down different theoretical perspectives. There is again that sense that rights and responsibilities are managed when these ideological understandings are imposed. Within a medical model for example, Greta is held responsible and she has a duty to respond to information about risk, going out to take control of dangerous situations. However, if she promotes the idea that people should develop psychologically, so as to become more self-responsible, more able to manage their symptoms, then that sense of duty is mediated differently (Salmon & Hall, 2003). But these participants

are not always able promote interpretations in complex disputes and these understandings are more often imposed by more senior workers. So the feeling of being stuck in the middle is experienced, where different people have contrasting agendas, but participants also feel vulnerable, as the situations they encounter can be given these different meanings, with significant consequences.

Participants in this chapter are not able to control the interpretations which their more senior colleagues impose. Ian gives a sense of feeling ashamed when he is not able to take control of situations and colleagues might criticise him. It might be assumed therefore that these colleagues on higher grades are more able to exercise control. But in the next chapter, participants who are employed in these higher grades give accounts in which they have even less opportunity to make free decisions of their own. A contrast is also found, where workers who hold senior positions defer to guidance and professional regulation, but participants in this chapter seek their own creative means of helping the people they serve. In this chapter, emotional engagement is experienced and participants are sometimes willing to be unpopular with senior workers, if this means that they can gain resources and help people.

These three workers gain a sense of themselves as active and effective decision-makers when they are working against the stultifying regulation of bureaucracy. They are willing to put their own feelings aside, trying to gauge and attend to the emotions of others, often tolerating risk or discomfort. They do not always operate within a cohesive team approach, while they encounter people who are at risk of death through overdose, harm through substance misuse or people who are damaging the physical envelope of their being in an emotive manner. It is then required that these

participants must intervene, whether they want to or not, although they do not feel repelled by these behaviours.

Greta talks about holding people in the sense that they have regular contact. Like Ian she does not want to abandon them or require them to resolve their problems on their own. However some forms of self-harm or risk-taking are viewed in our society as more socially acceptable, such as body piercing or extreme sports. In accounting for these actions people might want to retain the appearance of being rational and claim, so that 'sensible precautions are taken.' However this is missing the point. The behaviours of self-harm and risk-taking are surely designed to express a sense of recklessness. It is intended that these provocative actions should challenge others. There is a demand that someone should take control and hold the person in a state of safety, or give space so that the person must encounter their own random fate.

Emotion is not experienced as grounded in the individual disposition of the person, as the nature of this disposition is constantly in question. The values, motivations and the worth of various people in interaction emerge as aspects of different potential subjectivities, as different interpretations ebb and flow. An emotional disposition is read back into a situation, as workers are found to be caring or uncaring, depending on which interpretation prevails. In the next chapter, the experiences of workers who are employed in more senior roles are examined. The analysis moves on to address the influence of limited resources and risk on decision-making processes. Lower grade workers in this chapter give examples of their experiences in which they struggled to implement professional knowledge, where other people resist their interpretations. Knowledge is aligned with the exercise of power in these processes

and this is explored in more depth in Chapter 7, where more senior workers talk about giving information. The relationship between knowledge and emotion is clarified, where reference is made to abstract rational systems, which are intended to aid the regulation of emotion and determine the manner in which resources are managed.

Chapter 7: A process you may be entering: senior practitioners

Introduction

Following on from Chapter 6, this chapter introduces further experiences of professional decision-making. These experiences are more closely connected with guidelines and procedures in mental healthcare, as described by Diana, Harry and Kevin who are making decisions in senior roles and are described below. These participants have experiences which overlap with those of other participants, however they more often make decisions about the management of resources or risks and it is these experiences which are examined in this chapter.

Diana is an Asian woman in her thirties. She is a qualified social worker, approved to make assessments for detention under mental health law. She recently took the role of team leader for a community mental health team, where she manages staff and makes decisions about the allocation of resources.

Harry is employed as a staff grade psychiatrist. He is responsible for prescribing and managing treatment in both inpatient and outpatient settings. He leads decision-making processes on behalf of the consultant psychiatrist. He is in his forties and is Asian.

Kevin is a chartered psychologist. He makes assessments, providing therapeutic interventions in a clinical leadership role, in a community mental health team. He previously worked in therapeutic communities. He is in his thirties and he is White British.

Thematic summaries

Being real:

Participants encounter the reality of limited resources, where there are risks and it is difficult to set priorities. They are not negotiating so much as ‘managing expectations,’ while following professional guidelines. ‘Being real’ requires that they make unpopular decisions, using abstract rational calculations to ensure equitable outcomes. Professional decisions are experienced as weighty or substantial, while open to examination so that people feel exposed and subject to scrutiny.

Feeling protected when giving information:

Participants face challenging encounters with people who are distressed and in need. They make decisions which might be experienced as intrusive or a form of abuse, but these actions are understood to be required by professional policies and legal frameworks. By giving information on these systems of knowledge, they can pass responsibility back to the people who are seeking help.

An inability to control:

Participants struggle with processes of change and a lack of resources. They are unable to make commitments or build trust in ongoing relationships. It is suggested, however, that meeting people regularly fosters dependence, maintaining them in

unhealthy or immature states. But also, people appear awkward or complex, while problems might be quite ordinary when they are not viewed through the lens of professional judgement.

1. Being real

The experience of making professional decisions in the institutional systems of mental healthcare puts workers under pressure. They must gain agreement from different agents who hold different agendas, where there is a potential for conflicting interpretations. However, this becomes even more difficult where there is a lack of resources, where there are escalating risks and the reality is encountered that some difficulties cannot be resolved by mental health services. This means that participants in this chapter experience themselves as ‘being real,’ in an intense feeling of being human and very present in the situations they are encountering. Rather than opening themselves up to the interpretations of others, they promote one means of understanding which is their own view of reality. There is then a sense of managing expectations by speaking with conviction, in which there is an emotional engagement with the need to follow a particular course of action.

Before she became a team leader, Diana was employed as a social worker. She talks about offering choice and uses terms such as ‘compromise’ or ‘partnership,’ suggesting that she does not always experience herself as an expert:

I think that we should start using the word partners much more in mental health. We are partners, we are not an expert, an expert and a patient, I think we're equal, we're both got something to offer to this relationship (Diana: 414-417).

Diana has experienced processes of negotiation and she finds that people are quite strong in their stance; but also that her efforts to remain in control of resources and risks can feel like a pointless and painful activity:

It is about negotiation right, if you work with somebody, for example, who's got a very strong personality issues, they are going to want as much out of you as you can, and it sometimes, is, you are banging your head against a brick wall and sometimes it is hard, because the risks, the risks increase and escalate (Diana: 463-467).

You know I I work with a lady who having ideas of taking her own life, she was like, she actually said to me; "I just wanted to go away." The pain she was suffering, I said; "Well, I can't take away your pain but I can help you manage it." And that's not sort of taking away an expectation and dumbing anything down, it's actually just being real with her you know; "I'm not, I'm not, I haven't got a magic wand to take your pain away from you" (Diana: 485-490).

Diana is now responsible for managing resources and she often faces escalating risks, where she tries to reduce the amount of resources a person uses and this feels like she is banging her head against a brick wall. So she talks about 'just being real' with people. While she offers help, she does not set up expectations which cannot be fulfilled; she is clear that although there are risks she is not in control. She often manages expectations, not giving the impression that she will always be there for someone, because this is not realistic and it would only set them up to fall:

But the thing is you have a responsibility as a worker, as well, to support people in managing their expectations because the other thing is you don't want to set somebody up to fall (Diana: 482-484).

Rather than following the expectations of people who ask for support, Diana is attending to the responsibilities of her work role. She is 'being real' about the limits that her employed role places on her. So although she talks about negotiation, other people are not able to challenge her decisions. When she says that the other person has something to contribute to the relationship, perhaps she is only thinking that they have some responsibility for meeting their own needs. This is a similar experience to that of Kevin, who is assessing people on a waiting list for psychotherapy. He wonders if this involves any facilitation; any attempt to involve the other person in the decision:

Sort of facilitating, them to decide whether psychological therapy is appropriate for themselves? I don't know, that that does happen so much, it does feel like an assessment, it more often kind of comes down, to me, deciding (Kevin: 117-119).

When people believe that they can be helped by psychotherapy, Kevin does not always agree. This is not therefore a negotiated decision in which both parties have an opportunity to influence the outcome. He observes that many people think talking about past traumas will make them feel better, while in contrast, he suggests that there is little evidence to support this. Like Diana, he is managing expectations. He is getting people to recognise that talking about distressing events does not help them:

I think, so um is it, might it be empowering to say; “Well hang on can we should we think about this, like what’s happened to you when you’ve tried talking about this before?” Um I suppose just flagging up more factors in order to make the decision (Kevin: 408-425).

Kevin is informing people, so as to enable them to make better decisions about meeting their needs, while ‘managing their expectations.’ This is perhaps similar to Diana’s experience when she recognises that she cannot take away a suicidal woman’s pain. Kevin feels he is being real and empowering when he explains that therapy will not help. But at the same time he is drawing people into a discussion, so that he can use the information they give to support his decision. He sometimes feels that he is catching them out:

I am interested to find out their view, and there’s that thing, [laughs] it almost feels like, a bit of a trick, so you find out what’s their view and say; “Well that’s not, the sort of thing that we, [laughs] deal with.” (Kevin: 139-141).

In Kevin’s experience he finds that people sometimes provide an account which enables him to argue that psychotherapy is not an appropriate intervention for them. He laughs when thinking about this and perhaps he feels uncomfortable with this idea that he catches people out, feeling that he is playing a kind of trick on people:

It just feels a bit, tricky, or something, if someone says; “Oh yeah it’s awful I’m doing this, this and this.” “Well, sounds like you’re not, you know, your problems are too severe at the moment to engage in therapy.” And I think; ‘over shot,’ kind of thing [laughs] (Kevin: 594-597)

In Kevin's experience, some people assume that the more problems they mention then the more likely they are to be offered therapy. In contrast to this, he will not provide this treatment where people have problems which are too complex or too severe. People are providing him, unwittingly, with reasons for him to exclude them and his laughter is again a sign of discomfort; perhaps he feels that the business of psychological assessment should not be reduced to a game in which parties exaggerate or deceive each other to achieve their desires.

Kevin also talks about an abstract rational means of making decisions. He explains that there are only enough resources in his department so as to provide short-term work. This means that, even if Kevin believes that therapy would help, people would only be given treatment if they are likely benefit quite quickly. Although making comparisons can be difficult:

I think in terms of efficiency... if it's going to take them three years to benefit just a little bit, where as there is someone else who could be helped in eight weeks kind of thing. Then I guess we're leaning toward the eight week person, for, more kind of resource oriented reasons (Kevin: 229-233).

I suppose ideally, you'll be able to look across all the people waiting, and and put some some sort of, use, apply criteria in some sort of order of priority and maybe order them. But, you can't, you can only sort of see one person at a time. Um and and sort of comparing people is, very difficult, so it different, rather than doing everyone in parallel, and deciding, you know, in that way, you're seeing people in series, and

you're seeing them, you don't know what the next person's got but you're saying yes or no to this person, and then somehow to the next person. (Kevin: 476-483).

People attend for appointments, bringing accounts of various difficulties which add up to a kind of random demand on Kevin's time and the resources he manages. So he employs an abstract system in which the different people he assesses can be graded in an order of priority. However, while this is an attempt to base decisions on something that is real, or measureable, the calculation is not easy. He describes how he is trying to categorise and to achieve this he must set aside a lot of meaningful information, focusing on a narrow interpretation:

In order to categorise you need to ignore a whole lot of features of somebody and just focus on the one by which you're categorising them, and and that's how it works sort of thing you you could categorise someone in an infinitely, infinite number of different ways if you pay attention to all the things that they, present with, so we're screening a lot out in order to categorise people (Kevin: 916-920).

You're not sort of discovering or uncovering something particularly yeah, co-constructing something, and maybe your assessing whether the person is sort of able to get get on board with that process or something (Kevin: 937-939).

In Kevin's experience, he is not so much finding or discovering information about the people he assesses; he is not negotiating a mutually acceptable decision with the person; but instead is co-constructing an interpretation which will place them in categories; 'suitable for treatment' or 'not suitable for treatment.' Meanwhile Harry is

employed as a Staff Grade Psychiatrist and he also encounters this problem of working with limited resources. He observes that when there are many options these can be considered in depth, but with limited options, decisions might happen much more quickly:

Choice is deeper when you've got unlimited resources, unfortunately we've got limited resources, we have got um facilities that are limited the staff numbers, um, and the bed sizes, so so unfortunately we we are we have to we are under pressure to decide so many things, in a quick manner, so there are so many limitations (Harry: 156-160)

You need funding, there are so many barriers you know, you have identified that place there and stated that this is a place that can meet the needs of this particular patient, but you cannot because we have to go through funding panel and get to satisfy a huge number of people (Harry: 264-268).

It is required that when people need treatment in a psychiatric unit, Harry must find a bed for them. This often means that decisions about discharge must be made in a hurry, so as to make beds available. He also struggles with the need, 'to satisfy a huge number of people.' He must meet the agendas of others, or mediate complex decisions so as to free up his resources. Time is a factor which is experienced in a complex manner. Like Kevin, who tries to make comparative judgements about a series of people who are seeking psychotherapy, Harry is trying to make judgements over who might have a greater need for a hospital bed at a current point in time, when new information might arise at any point, which would change priorities. Again, there are

limits and barriers which are very real for Harry. He talks about being sincere when he is negotiating or communicating:

Negotiation is one of the important, part of our training programme as well, communications skills, how to negotiate, so if we are quite clear about what we want to talk about, and in a sincere and, way, the people do accept (Harry: 337-339).

When he is talking about persuading people to accept treatments which they might not want, Harry also experiences a need to express sincerity. He mentions a depot injection which is a slow release form of sedative medication which is injected into a large muscle such as the buttock. He feels that his own conviction should be enough to persuade people:

For example if we do understand that some patients need this depot injection, and they don't, they're not willing to take it and they know that they are going to deteriorate then they negotiated that, tell them the benefits, sometimes um, you know we have to be, a bit assertive in there, because if you're very convinced of the beneficial effects of whatever we are doing, it's positive if you are convinced from a, all along that this is the right thing for this patient, professional speaking (Harry: 356-362).

Harry experiences a need to be assertive and to express conviction when he is trying to get people to accept a treatment, or achieve other outcomes. He is, like Diana and Kevin, trying to emphasis a reality he experiences, that keeping people well and out of hospital is extremely important. Diana also talks about this imperative to help people

stay out of hospital. She contributes to assessments under the Mental Health Act and discusses the prescriptive criteria for this act, under which people are held and treated against their wishes:

The Mental Health Act work is very prescribed, you have a very strict criteria to follow and you know, so you know you you have to, your your practice there definitely is detaining, you cannot, I mean they say that you look for the least restrictive option when detaining somebody but it is either you are detained or you are not detained (Diana: 72-77).

Diana is obliged to follow the guidance associated with this form of law and people are either, removed to a psychiatric hospital and treated against their wishes, or they are not. She is then, from her point of view, informing people when she assesses them:

If people say to me; "I am going to stop taking my medication." and I say; "But you know what happens if you stop?"... I'm actually being quite informative with them saying; "Now look, I'm a a AMHP, my job is this, X,Y and Z," and I did this with one of my, one of my service users... I worked with him and he just seemed to spend most of his life, stopping his medication, getting kicked out of his accommodation, going into hospital (Diana: 707-720).

Although she can detain people under mental health law, as an 'Approved Mental Health Practitioner' (AMHP), or an 'Approved Social Worker' (ASW), in Diana's experience she is just being informative. She is being frank about the way the world is

and what happens. She is reminding this man of the manner in which he spoke to her in the past:

I said; "You know that I am an ASW, you know what I do, I've actually detained you before." "Oh yes you have yeah yeah yeah, I really sorry I told you to, I remember I told you to F off." "I said yes you did, and that's very," I used to say to him but. So I could I could have actually quite frank conversations with him, to say; "look," and I didn't feel that was a threat or anything. I was just telling him that this is the society, this is what going to happen, it's not, it's not a threat (Diana: 722-728).

Diana does not experience herself as threatening. She feels she is just observing a pattern of events in which a man is repeatedly detained in hospital. Diana believes that he should learn from his past experiences and that this should motivate him to accept treatment. She is seeking an adjustment or an orientation to understandings which she experiences as real; she is trying to help people to accommodate her interpretation of these realities. But she is aware that her words could be threatening, while from her point of view, she is only providing information.

The action of just giving information can appear at first to be rather remote or emotionally disconnected. But Diana, Harry and Kevin are aware of themselves as emotionally engaged in managing decision-making processes, where pressures are real for them and they feel very present in these situations. They are emotionally engaged in activities which matter to them and Kevin, for example, compares decisions at work with his home life, where some choices do not matter so much:

I'm thinking of the sorts of decisions I make at home ... Like 'what am I going to have for dinner tonight?' feels quite easy usually, um, one because it doesn't, er if you make a wrong decision it doesn't feel like it matters very much... Whereas I sus, the decisions at work, feel, I suppose the the clinical decisions, feel more, generally feel more weighty (Kevin: 707-714).

Decisions at work have a degree of substance which makes them worth attending to, in comparison with ordinary everyday choices at home, which do not matter very much. Choices at work are recorded and, if there are risks, it is possible that these decisions will be examined. It is important therefore to know who made them and to be able to argue that they were made on rational grounds. While in contrast to this, perhaps at home, some ambiguity about just exactly who instigated a particular choice can be tolerated, because it does not matter so much if it goes wrong. Decisions which Kevin faces at work might be under scrutiny at some point:

I suppose, there's also this, thought at the back of mind that it's might be kind of being scrutinised somehow, or it might be up for scrutiny at some point you know if something goes wrong, and why did I make this decision which is all a bit, I suppose I can find it a bit sort of paralysing at times actually, whereas at home, we could make decisions very um, quickly about things, because it doesn't feel like that sort of scrutiny is there (Kevin: 731-736).

The responsibility of taking on employment at a higher grade in mental healthcare brings the realities of risk, uncertainty and limited resources to the fore and Kevin can feel that he is being watched; an experience which causes him to feel paralysed. Diana

also talks about feeling exposed in her new more senior role, where she can no longer access her familiar support network. She feels that people are going to see if she makes mistakes. In contrast, the support she experienced in her previous role was like an invisible ring around her protecting her:

You feel a lot more exposed, cause you haven't got that, network, that, whatever, I don't even think it's a it's not even a fence or something, but it's some kind of ring, this invisible ring around you, that that security that even if you did falter, there would be people to pick you up, but you know that if you step outside of that ring you are going to be like, ooh gosh, people are going to be, to see, what's up with, but the thing, people are going to see where I have gone wrong (Diana: 167-172).

Diana has lost a familiar form of protection which shielded her, providing security. In her old team, if she faltered her colleagues would notice this and then pull together around her to help. However, having stepped out of this protection, she feels exposed: she is visible and her mistakes will be seen by people who might not be so supportive or protective. Perhaps Kevin and Diana cling to the details of policies and protocols because they would feel shame if things go wrong.

Participants in this chapter cannot engage in processes of mutual decision-making in which the desires or opinions of other people are considered in depth. They experience a need to express sincerity, to be real or frank, to communicate the urgency of taking particular choices, due to an understanding of the situation which is based on professional knowledge. Diana gives the example of negotiating with a woman who feels suicidal. She could not promise more visits or more support. This

feels to her like she is banging her head against a brick wall, an encounter with a hard reality. However, although these realities are very real, they are also quite abstract. People present to mental health services with complex individual stories about their problems and needs. Somehow, information must be extracted which can be compared in a rational abstract calculation, so that priorities can be set.

Particular interpretations are being promoted, so that rational decisions can be made in the management of limited resources. Time is complex in these calculations as it cannot be known what level of demand might be made on the service in the immediate future. Decisions are made at one point, which might then be subject to scrutiny and potentially seen as wrong when viewed with hindsight. A reliance on rational systems is important, therefore, so that consistency can be demonstrated. However, these systems are experienced as arbitrary, abstract or difficult to calculate. While in one moment there is time to invest in helping a person, at some point later, providing that help is no longer a priority. But participants in this chapter are motivated by a desire to ensure the integrity of their organisational systems. They only meet needs, therefore, when this fits within a rational management of resources and they refer to pragmatic forms of applied knowledge, as recorded in policy, research, legal guidelines and professional protocols.

2. Feeling protected when giving information

The technical knowledge of mental healthcare originates in the guidelines provided by professional bodies, in work based protocols, in research evidence, in mental health law, and in other established practices. Participants suggest that when they fall under the influence of these understandings in their working lives, any sense that they are

acting as individuals is lost. They are not then following their own preferences. But there are benefits, because if they are called to account, workers could demonstrate that decisions are a shared and routine aspect of their work setting, rather than a personal choice.

When blame can be attached to the system, rather than the person, participants feel that they are protected. Whether they are making decisions which are based on the knowledge and experience of professional bodies, or following guidelines, or just informing people as to the nature of mental health law, they do not experience themselves as engaging in personal conflicts. They are not competing to get what they want or fulfilling their own desires.

Diana describes the procedure of making assessments under mental health law. She reflects on these practices and expresses her belief that it is her role to inform people, while she is also aware that this can be heard as a threat and she gives another example of this apparent misunderstanding:

I worked with somebody with an eating disorder once, and her BMI was plummeting, and it was, it was getting life threatening... and I said; "I've spoken to the doctor, and, we spoken about, you know that the Mental Health Act might be an option." She's a very intelligent functioning lady, and she said; "Are you threatening me?" I said; "I'm not threatening you, I'm informing you about a process that you may be entering" (Diana: 728-739)

She recalled that bit; said; “You do actually realise that that day was a turning point, your honesty, actually brought me, brought home the reality of the situation, that I could end up in hospital if I don’t take responsibility.” She still says; “You were threatening me.” I said “I wasn’t threatening you I was informing you. But it is how you see that information” (Diana: 763-768).

Diana works with a woman who is dangerously under weight. She discussed the possibility of detaining under mental health law at some point in the near future. So a paradox is expressed when Diana believes that she is giving information; the information that this woman might not be thought able to make the decision to eat or not. But if this woman were unable to make this decision, there would be no point in informing her, as she would not be able to act on that information. However, the woman started to eat some toast in response to being told about the potential for detention, so she did therefore have the ability to choose and would not be detainable. Diana is then aware that, in providing information, she is being perceived as making a threat, as bullying.

Diana could be pulled into a complex dispute with this woman. She might feel a strong human to human connection in which she would want her eat more and maintain her health; while the woman might experience this as an interpersonal pressure which takes her autonomy away. However in Diana’s experience the interaction can be framed in a simpler understanding. For her, the possibility of meeting criteria for detention is no more than a shared reality which is part of society and she is only trying to help people understand this. In emphasising the notion of ‘just giving information,’ she positions the woman as a free agent who can choose

how she ‘sees that information.’ Once information is passed on, it is up to the other person to respond to it, as they wish, although Diana hints at what a more reasonable or rational choice might be:

I did actually think; ‘oh my God is that kind of, kind of, kind of collusive, was that kind of bullying?’ But I was thinking; no, isn't it better to be informing people, that this is the process, that because of the fact that, rather than two doctors and a social worker turning up at your door step, what would you prefer? (Diana: 741-745).

In her own understanding, Diana is trying to be straight and honest in her dealings, letting people know what might happen if they make particular decisions. However she is taken aback by this woman who eats because she feels threatened. From Diana’s perspective, any decision this other person might make when they are informed, is their responsibility. She is not therefore investing her own time or effort in maintaining this woman’s wellbeing, by making her eat, or taking on that responsibility. Diana is, therefore, placing emphasis on interpersonal separation, giving information is a means of passing responsibility back and displacing anxiety onto the other person. Although she points to rationality, there is clearly a powerful interpersonal emotional process. Perhaps this kind of action, in ‘providing information,’ could then be understood as a means of managing the less tangible emotional aspects of living with uncontrolled demands and risks in interpersonal encounters; a form of protection. Kevin for example talks about feelings within the department in which he works:

It's like, there's this feeling we can't we can't take any any more people on, and we have to pin a rational explanation to this... So it's more emotionally driven or, in terms of resources really but um, then a bit sort of dressed up with again rather cynical view, but, it's, like, it's not, it's quite hard to say, well we can't see this person because we haven't got capacity (Kevin: 505-511)

Kevin feels there are just too many people seeking psychotherapy and resources cannot be stretched to meet their needs. This feels overwhelming and a lack of service capacity is not an acceptable reason for refusing to help someone. Questions could be asked as to why one person is not being helped when another person with similar needs is given a service. Equality of access is expected. So Kevin would feel exposed if it was thought that his refusal to provide therapy to someone was based on his personal feelings, while that person might quite reasonably feel rejected. So the abstract rational calculation he mentions provides an impartial means of making judgements.

Kevin is suggesting however, that these decisions about who gets psychotherapy are actually driven by underlying emotions and then 'dressed up' as rational clinical decisions, because this is seen as more acceptable. But Kevin does not feel he is making choices based on his own will and he wonders how much he is able to make his own decisions, or how much is he following guidance, based on the experience of others:

I suppose ultimately the sort of evidence on which it's based is other people's experience, which I'm drawing on because I've read stuff or I've had, guidelines and

things, um, so it's not fully, my decision, it's hard to know what, I don't know things are more philosophically, it's hard to know what it would mean to be, my, my decision or what something that is completely my decisions would be (Kevin: 246-250).

You've got to draw on other people's experience and knowledge haven't you... I suppose you can say that's my decision based on that stuff but in the, well I don't know, isn't it I don't know, this is the philosophical point I'm slightly struggling with (Kevin: 370-373).

Kevin does not experience himself as acting independently of the knowledge systems he shares with his colleagues. He struggles to envisage a kind of decision which could be thought of as entirely his own, and he expresses awareness of complex philosophical questions which arise from this. Although Kevin refers to decisions at work as weighty and he experiences an emotional investment, he is not able to say that he is making those decisions as an individual. Kevin's personal choice is, therefore, experienced as separate from the rational system in which he operates. He imagines how things might be if his choices were not determined:

If I was completely sort of free within this service to do I wanted I'd quite like to have a couple of people I'm seeing for three years (Kevin: 267-269).

Because this decision is taken away from him by the established service policy, it is not Kevin's personal choice to deny therapy to people who cannot be helped very much. Any responsibility that he might feel is passed back to the person when it is explained that the evidence shows that therapy is not going to help them anyway.

Diana also talks about choices being limited at work, because her employing organisation gives defined targets. She manages a team in which workers go out to help people engage in activities in their communities and this work is complex. However, she describes new commissioning and monitoring arrangement in which the work is more closely defined. This limits Diana's options and she feels that some of her choices are already made for her:

I think some of our decision making processes are actually dictated by sort of the governance presented by the organisation that we work for... We are told and dictated to sort of, by with regards to 'Payment by Results' and we have to do a certain number of contacts in the week (Diana: 27-30).

Due to new forms of imposed structure and rationalisation, Diana feels she is more often doing that which is set out in advance through a system of governance. 'Payment by Results' is a part of a commissioning system of 'Managed Care' and Diana does not feel that she is choosing to see people so much as recording contacts so as to fulfil a commissioned contractual arrangement. Harry also describes how his choices are limited. Some of these decisions lead to intrusive interventions such as 'rapid tranquilisation,' in which a group of workers physically restrain someone and inject them with a sedating medication. However, he does not experience this as a personal choice in which he is responsible for an action which might be experienced as a form of assault:

The [NHS] Trust always provides guidelines, um on acute way of treatment, and we have to remain, in those guidelines, um we cannot do anything against, so so

whatever the the process we go there is for example if a patient needs a rapid tranquilisation, that then there is a rapid tranquilisation policy, we have to go according to that policy and according to the protocol (Harry: 125-129).

In Harry's experience, he has no choice but to follow guidelines and policies. Also, Harry acts as part of a team, both in the hospital and in the community. He finds for example, that his suggestions around what medication he would prefer to prescribe are challenged. He recognises the expertise of his colleagues and observes that their views are taken into consideration:

We work as a team, so it is um, not one person who is um, an inpatient and similarly in the community, it is a team decision, which is um, considered, because we have to work as a team (Harry: 133-136).

For example if I, feel that a, particular medicine is needed, then I have to discuss, with the team, with my seniors, even with my juniors, and with everybody who is going to administer that now we are planning this, and people in the team they they do object they do give their suggestions, so yeah then in some stages they even, because they've been working in this field for quite some time, so they think the yeah, they're their point of view is always taken into account (Harry: 140-145)

Decisions are made with a high level of consensus amongst a number of people. Harry must negotiate and the more qualified and experienced workers are influential, suggesting that it is the knowledge that they accumulate which is important. If there are problems with a prescription he has written, he is held to account as an individual,

but the experienced workers who administer the treatment will also object if they believe the treatment is inappropriate.

Diana, Harry and Kevin are not often able to make choices of their own. They cannot step outside of their professional roles, to show themselves as human in the choices they make. They are engaged with hard realities which demand that difficult or unpopular choices are made. By referring to systems of rationalisation or professional knowledge they protect themselves. So, in their own experiences, Diana is not threatening people with detention under mental health law, Harry is not requiring that they are physically restrained and treated against their wishes, and Kevin is not refusing to provide psychological therapy. These actions are outcomes of various rational systems, which these people are enacting, as anyone in their position would.

Participants describe how they experience their own personal choice as something which is separate from the decisions they are required to make in their employed role as a professional providing a service, or as a member of a team. They are aware that other people might experience them as engaged in an emotive form of personal conflict, or a power struggle, but this is not how they experience themselves. They do not then feel that they are expressing their own will in the choices they make. While this alienation from their own being might be thought of as problematic, these participants feel protected. While at the same time they are clearly emotionally engaged in the decisions they facilitate, driven by perceptions of necessity and need. However, the responsibility for taking rational actions can be passed to others, when they are 'informed.' Emotional processes are in play in these encounters, but there is a strong sense of separation between people.

3. An inability to control

Mental healthcare is a setting where reference is made to complex established practices, grounded on various forms of professional and legal knowledge. Participants describe their efforts to persuade people that the information they hold is very real and should be acted upon. They are employed to apply professional understandings by which people are detained, treatment is enforced and resources are granted or withheld. But this power is an expression of the institutional routines and knowledge systems which govern their employed positions, rather than an aspect of their individual or personal being. Also, this applied knowledge can make the people they serve appear more chaotic, because they do not fit within the standardised system.

Participants are aware of the limits of their formal professional knowledge and they know there is a world outside of mental healthcare, in which people make sense of their lives in other ways. It is only within the systems of mental healthcare that they can be certain of holding status or applying their knowledge. Even in this setting their status is precarious and knowledge changes over time. Participants do not often feel they are in control as they struggle to manage these processes of change.

Policies and targets are constantly changing and Diana talks about feeling distressed by the thought of services being organised in pre-arranged systems. In her experience, plans are difficult to negotiate and often change:

I was quite terrified yesterday, in the training, that I heard they are going to sort of, following sort of, from the first appointment diagnose people then work to a menu of what interventions (Diana: 531-534).

Care plans can change weekly sometimes and I think you know it's a shame we have these, we have to go through so many loops electronically to change it because I think you know it is an ongoing process you can't it isn't something that is the same every week. (Diana: 561-564).

Diana finds that prompt assessments are expected, leading to predefined interventions. But the electronic recording system is inflexible and it is hard to adapt to the changing needs she encounters. Further complications then arise when Diana's work involves making interventions that are grounded in different and sometimes incompatible theoretical or philosophical models. Interpretations of her actions vary dramatically, so that expected rights and responsibilities are suddenly switched about in an alarming manner. In experiencing this constant flux, Diana feels pulled in different directions, as the conflicting logic of two forms of understanding are applied. She might be offering choice and being creative one moment, but then, denying choice a moment later:

One minute you are being creative and offering everybody every option and as soon as it comes to the Mental Health Act it's like; "Well, if you don't take your medication you've got to..." you know; "If you don't to this and you don't do that and your risks are increasing, then you've got to come into hospital because that is all we can

offer.” which for for I think for a social worker in mental health it can be quite challenging (Diana: 83-88).

Diana sometimes works to empower people by offering choice, helping them to find their own means to overcome their difficulties using recovery philosophy. But in contrast, the assessments she makes under mental health law promote a biomedical understanding; *“Another part of my role... Mental Health Act work, which completely contradicts the other work that I do.”* (Diana: 71-72). These are therefore conflicting approaches, although Diana’s actions are rational when understood within one or the other of these different means of understanding.

A lack of resources remains a problem for Diana who wants to help people to understand that it is a sign of progress when they manage their mental health problems while receiving less support. Although she also feels that this kind of change is petrifying. She uses the analogy of a comfort blanket, a reassurance which people must learn to do without:

I think for some people it is absolutely petrifying because in the, in the background mental health services can be, a comfort blanket; don’t really use it, it’s just tucked away in the cupboard really, but it is nice to have if you get a bit chilly, whenever that may be. But unfortunately, you know again, it is sort of we are being dictated to, it would be great if we could have that blanket forever, but in the, it, within the climate that we are in at the minute with Social Care and Health, we haven’t got that luxury (Diana: 256-262).

I think change is good for people, and also it's good, it's good for them, because they become kind of reliant on us, it's good for a team, because they too can become dependent on clients, and I think it is just healthy all round (Diana: 262-265).

In Diana's experience, change in the form of discharge from hospital or from community mental healthcare can be positive. Coping without a comfort blanket is perhaps a growing up process, although it is not clear how much this is driven by learning and maturing, or by financial constraints through which resources are denied. Diana appeals to the people she is working with and she observes that; *"You have to say to them; 'This is what's going on, you know, we are all grownups here.'"* (Diana: 832-833). Diana associates these processes of change with the notions of being 'grown up' and 'healthy,' as if depending on others is a kind of childishness, or a disease which infects both workers and the people they are trying to help. However, adapting to the reality that resources are limited is not just about growing up; there is also a sense of loss; of things not really fitting any more, when the 'comfort blanket' is taken away. Diana is only able to offer basic medical interventions, which are seen as the priority:

So if I have, only four members of staff in and I have got to go and deliver medication, go and do depots, that does take precedence over someone perhaps wanting to go on a longer sort of, a, a trip say to the countryside to go for a walk and stuff because they think it is good for their mental health, their wellbeing and their physical health... It's not sustainable, so um, it's kind of like going into a store, seeing a dress you like but them not having your size, it's there but you, there is nothing that will fit (Diana: 326-335).

Diana does not have enough resources to provide the support people are seeking. Nothing fits and there are needs which are not met. This is another frightening challenge she faces and as stated above, she is petrified by the idea that she might have only a limited number of options to offer people. Her time and resources are increasingly controlled by organisational systems.

Kevin finds that there is a world beyond the control of mental healthcare and he picks out specific information so as to interpret people within the meanings of professional knowledge. However this is not always possible and some people he assesses do not fit, they become thought of as difficult or hard to treat. Kevin is aware that this creates the impression of problem people, rather than ordinary people who happen to be facing problems:

The structure makes you think, that this person just doesn't fit kind of thing, so it might then actually make them look chaotic, or even more chaotic than they actually are, where actually they're, a person struggling to deal with the things they've got to struggle with, whereas they look like somebody who you can't pin a diagnosis to and they're a sort of clinical enigma sort of thing... they're hard to treat, but it's just because they're er really we're saying it just they're just normal people (Kevin: 879-889).

People appear chaotic because they do not fit within the structure of professional knowledge, as it is applied in the healthcare system. The people Kevin assesses are living their lives and employing their own means of making this meaningful for them. Kevin's professional approach to applying knowledge is at odds with these lay

understandings and there is a sense in which he might struggle to get his understandings across:

There's someone I've seen, a number of times... whenever I meet him he just spills out loads and loads of stuff about, what's happened to him in the last week and; "This this happened to him and this was awful." And so on, um, and it's very, it's hard to get a word in edge-wise, in the first case, but um, when I actually, when I do, and um, sort of stop him and and more forcefully say something, he's said to me before, he doesn't take it in, cause he's so focused on, something else (Kevin: 271-278).

Kevin cannot always get the people he assesses to think about their difficulties as psychological problems, which they might address through a therapeutic process. This man he describes, who 'spills out loads of stuff,' does not fit within the healthcare system; *"He sort of goes, beyond kind of what we can provide or somehow doesn't fit."* (Kevin: 318-319). Kevin experiences a limit to his ability to control others and he cannot even open his understanding up to take in the world of the people he sees; because he cannot help them when their needs go beyond what can be provided. He cannot hear their voice because of; *"The number of people we see and the um, the the sort of horrible difficulties that they're bring and they're faced with themselves."* (Kevin: 855-856). Diana is also hindered in committing resources or investing in relationships, because she cannot guarantee to meet these commitments and she was tripped up by this in the past. She is now careful in the way she words her care plans:

I've always suggested things in care plans that I know realistically can be met, and you know and I I I, word things as well so that I don't get sort of tripped up (Diana: 364-365).

You need to put expectations in the care plan that you are not, going to break really, because that is really unfair (Diana: 383-384).

Participants discuss a need to manage expectations and Diana, finds herself 'tripped up' when over committing in her work with people. She goes on to paraphrase the kind of things she might say to a person she is helping, in which she is expressing the belief that it is better for them if they can learn to manage their problems in their own home and community, rather than seeking a medical interpretation of their difficulties. But it is a challenge for her to get this across:

"Because you're around people, you are in a normal homely environment, it's not, it's not, we are not medicalising your problem..." "Your community is a much more richer source of support and service than any kind of mental health team could provide." But because it is all she has ever known, it's, it can be quite a challenge to get it over (Diana: 221-228).

Diana believes that delivering care and treatment at a mental health community centre or a hospital does not provide as much opportunity or choice, as would be encountered in an engagement with a community. But it is a challenge for her to get this information across and Kevin also finds that it is sometimes 'hard to get a word in edge-ways.' So when Diana and Kevin struggle to inform people, they also struggle to

exercise control. They experience a sense of anxiety and Harry also mentions this. He prescribes medications, but must gain the agreement of others. He feels that the need to gain consent means that those who take treatments have a lot of rights; *"So the service user has um, all the rights, they are totally involved, in the decision making process, as far as community treatment is concerned."* (Harry: 192-193). This lack of control is scary and although it might be expected that the people for whom Harry prescribes treatment would experience him as powerful, this is not how he experiences himself.

Taking on a role at a more senior level in mental healthcare is a challenging experience. Promoting professional understandings is a core means of managing complex problems, which are often beyond the control of these workers. But even if a degree of control or regulation is achieved, the knowledge systems on which this is based are subject to constant change, and the feeling of being protected is fragile. A failure to change might be interpreted as a kind of unhealthy or childish clinging onto dependence on others. Participants describe how it is difficult for them to encounter the individuality of the people they assess. Fitting diverse complexities within the structured understandings they employ can mean that people who face ordinary problems are interpreted as 'problem people.'

Working within a changing system of governance, with pre-determined meanings and actions, can cause participants to experience extreme emotional responses, when they are 'feeling terrified' for example. They are struggling to help people where there are conflicts in the manner in which meanings are applied. Participants are concerned that, if they do commit to helping people, they might not be able to meet these

commitments. However, the people they try to help express rights and expectations, which contribute to that feeling of not being able to contain or control. A close adherence to policies and protocol is therefore understandable as an attempt to feel some form of consistence and coherence.

Conclusion

The use of rational calculation in the allocation of limited resources can appear as ordinary and reasonable in the accounts given in this chapter. If decisions are made following the usual steps, as required within the available guidelines, participants feel that they are just doing that which is expected of them. However participants who contribute to other chapters find these regulated decisions lack qualities of human emotion, creativity or connection with others. While workers in the previous chapter seek to achieve personal expression and a sense of self through creatively working against the flow of bureaucratic systems, the possibility of personal expression is somehow lost at a senior level of employment. This is counter-intuitive, as the ability to be creative and flexible, or the opportunity to find variety in daily work routines, are more often associated with senior roles and this autonomy is thought to protect against burnout or depersonalisation (Dallender & Nolan, 2002).

Losing a sense of self is an experience which participants in other chapters have encountered and Erving Goffman describes how people can be stripped of their identity. When entering a medical institution, for example, people are often required to remove their own clothing, becoming a patient, defined as a diagnosis (Goffman, 1961). So it is interesting that through the processes of psychological assessment, Kevin has the experience of filtering out a lot of information so as to construct

identities such as ‘suitable for psychological therapy.’ But in doing so, Kevin is also stripped of his own individual identity. He adopts a professional identity, being socialised through years of training into this role, so that he see himself as a member of a professional group (Dombeck, 1997).

Participants learn to understand their experiences in the same manner as their colleagues. But in contrast, participants in Chapter 4 brought their own everyday understandings and gain a stronger sense of their self when expressing their will in conflict with that of senior workers. They draw a contrast between their own emotionally engaged experience of this conflict and the apparently emotionless, structured and hierarchical decision-making processes of mental healthcare. It might not be expected, therefore, that participants in this chapter should speak about feeling emotionally engaged in making decisions. But they describe a need to be sincere, or real, for example. They experience themselves as active when established procedures are followed, making weighty decisions, as required within agreed forms of governance.

Participants in this chapter are driven by necessity and need. This is in some ways similar to experiences described in other chapters, in which there is a struggle to feel in control. The notions of control and autonomy are considered in Chapter 5, where Anna speaks about having her rights and choices taken away, when threatened with detention under mental health law (Chapter 5 pp. 159). Participants in that chapter describe their difficulties with making choices when their emotions fluctuate due to the affects of a mood disorder. They are caught up in processes of self-regulation as a consequence of experiencing this loss of control. A similar experience is happening

for participants in this chapter, when the stark realities and unpredictable demands, with which they are confronted, cause them to make contained and predictable choices (Foster, 1998). They are held within the systems of mental healthcare, while encountering a world outside of this institution as chaotic, full of diverse meanings. They cling more closely, therefore, to the structure and detail of professional practice.

While participants in the previous chapter speak of changing their behaviour so as to appear to be similar to the people they assess, in an attempt to overcome differences in the ability to exercise power, participants in this chapter are more concerned about promoting their professional understandings. Problems occur again however, where there are different possible interpretations. Diana describes, for example, how choices can make sense within the logic of either recovery philosophy or the medical model and these understandings are often incompatible. Workers bring different interpretations from their professional training, promoting understandings at the different levels of biology, psychology and sociology (Colombo, et al., 2002).

In the previous chapter, participants spoke about struggling to meet different agendas and trying to forge a consensus, which often seems to be a rather fragile form of agreement. This task of maintaining equitable relationships is also experienced by Harry in this chapter. When seeking funds to support processes of discharge from hospital, for example, there would be a need to pay constant attention to ensuring that everyone feels involved and respected. Then, failing to choose that which others would prefer would create disharmony and people might feel they are excluded, rejected and unheard. When they are attempting to facilitate agreements, participants on lower grades were motivated to please people and they might feel they have value

as a person, when experiencing the positive evaluation of others. But participants in this chapter accept that they are more often called upon to make unpopular and contradictory choices. They feel protected, as these choices are not personal, but required within the rational systems which govern their actions in this work setting.

Kevin speaks about his own personal choice, which he would make if he were free to do so, as different from that which is required of him within his professional systems. Practices are guided by the knowledge of colleagues, while these practices are experienced as abusive by the people they are trying to help, so that this raises difficult and contradictory feelings (Bigwood & Crowe, 2008). There is more separation between people in the accounts given in this chapter than those of the previous chapter where participants speak about their efforts to hold or contain others. The more senior worker in this chapter talk about ‘informing people,’ so that whatever those people do with that information is up to them. John suggested in Chapter 4, that helping someone recover mental health involves ‘holding their hand while they start off on a difficult journey’ (Chapter 4 pp. 124). However Kevin in this chapter feels that the action of just giving information on which a rational decision could be based would in itself be empowering. Behind this rationality, there is a complex emotional exchange through which responsibilities are imposed.

In Chapter 4, carers and support workers find that the processes of assessment and professional judgement can be experienced as cold or emotionless and lacking emotions is conceived of as pathological response to feeling out of control. Psychological research proposes models such as the notion of ‘Compassion Fatigue’ (Sabo, 2006), or the idea that distress can be passed on, as if it were contagious

(Sinclair & Hamill, 2007). In these interpretations, emotional connections such as empathy are understood as natural human qualities which might be lost when workers are overwhelmed (Acker, 2010). However, as discussed in the previous chapter, the experiences of participants in this study suggest that there are no grounds on which to claim that these theoretical models refer to stable or predictable processes. Instead they appear as an aspect of interpersonal conflict, where there are rhetorical disputes within which the value, the humanity, or the professionalism of participants might be disputed.

Emotional processes are at play when professional judgements are made and information is given. The management of rights and responsibilities can, again, be seen as an outcome of imposing particular interpretations. In these processes, following procedures and adhering to policies is an important means of managing an unsettling feeling which is triggered by the possibility of being seen to make mistakes. Participants would not want to be visible as individuals who commit ‘human error,’ in processes which require a machine like consistency and reliability. The experience of shame and emotionality underpins these reliably performed processes, as participants describe how they encounter a form of reality which is ‘hard,’ or ‘weighty’ and this substance provides an emotional orientation to something more tangible than their own whims or impulsive choices, or those of other people.

In the next chapter, different accounts are explored; where three participants make individual choices in isolation. Harsh realities are also experienced by these participants and concerns about control, freedom and institutional regulation are brought to the fore once more. But then, the experience of isolation brings the analysis

back to the perspective of the individual, as a separate person who attempts to express their will against the authority of mental healthcare and related social structures. The notion that fostering dependence on others is somehow unhealthy arose in this chapter, while in the next it is the idiosyncratic ideas which people develop in isolation that are viewed as pathological. The experience of passing responsibility and associated anxieties on to another person, by ‘informing them,’ is discussed by Diana in the current chapter. Then, in the final analysis chapter, participants describe how they avoid taking on these understandings, often living in a manner which relieves them of any responsibility.

Chapter 8: at arm's length: experiencing psychosis

Introduction

In this final analysis chapter, decisions are described by three further participants. These decisions are made in isolation or in relationships where there are extreme forms of conflict. Distressing experiences such as physical abuse are mentioned along with detention under mental health law and enforced treatment. A sharp contrast is found between the complex interpersonal decision-making processes discussed in the previous three chapters and the insular or subversive choices explored in this chapter. Ben, Chris and Laurie are all diagnosed as suffering from psychosis and brief introductions are again provided below. The experiences to which these participants refer are explored in the three themes described below. These provide another perspective on decision-making processes and there are some similarities with the lay understandings explored in the first analysis chapter. The over-all analysis is brought back to its starting point.

Ben is White British and in his sixties. He has endured experiences of psychosis throughout his life with excessive use of illegal substances; mainly amphetamine sulphate but also cannabis and L.S.D. He was at times detained in psychiatric hospital or prison, but also lived on the streets, moving from town to town. He has been arrested for crimes such as vandalism and assault. He is currently held under mental health law and placed in a residential home.

Chris is White British and in his thirties. He was diagnosed in teenage years as suffering from psychosis, but also uses cannabis and alcohol. He was detained many times for short periods in psychiatric hospital and was at one time placed in a supported hostel, but he now lives in a rented flat.

Laurie is White British and in his fifties. He was diagnosed as suffering from psychosis in his twenties; enduring periods of homelessness and isolation. He lost this job and his home, being detained for periods in psychiatric hospitals.

Thematic summaries

Randomness and wandering:

Participants open themselves to new possibilities in life through random wandering. They need to feel in control, which limits their ability to make choices with others. They do not make commitments and avoid mental health services, often remaining estranged from family and friends. This flight from shared living includes both physical distance in wandering and mental distance in the excessive use of alcohol and illicit substances.

From mistrust to paranoia:

Detention under mental health law is experienced as an intrusive loss of control. Participants feel ground down by the monotonous routines of institutional life. Their decisions are then reactive and unstructured; while mental health services are not able to give back control or offer meaningful choices.

No right way to be:

Participants seek to be separate, feeling different and at odds with others. A lack of control over their own behaviours, or an inability take responsibility for their actions is suggested and while this might appear to grant them a kind of licence or freedom, they still experience difficult feelings of emotional connection with others.

1. Randomness and wandering

There is an experience of freedom in the ability to roam at will and this phenomenon of wandering arises in each of the accounts given here. Losing opportunities and wandering is at the core of the experiences these three participants have endured. Although, to a degree, they feel they have chosen an alternative way of living, they also explain that they are not able to settle or make commitments to others. Their lives have not turned out as they would want and there is a quality of 'happenstance' in relation to the decisions they make. Decisions are focused on short-term goals, often responsive, or just granting immediate gratification. The experience of detention and forced treatment under mental health law only increases this lack of direction in life.

Ben makes choices in response to random occurrences, feeling that there are hidden forms of meaningfulness in which fate indicates the path he should take. He does not believe that he is in control of his life and feels he is controlled by others; *"Life isn't always what you make it, it is sometimes what other people make it."* (Ben 21-22). In his wandering Ben experiences a sense of avoiding the influence of others; an escape in which he is then open to chance happenings. He mentions a fortuitous experience when getting off a train in a seaside town; he sat on a seafront bench and a woman gave him a flask of coffee and sandwiches:

Well I got off the train... and sat on one of seafront the benches and a woman came down and gave me a flask of coffee and sandwiches for me. I thought why I have never never its such such a shock I I thought I couldn't believe it I'll stay here forever [laughs] (Ben: 197-200).

Ben decided to stay in a town because of the kindness of a stranger; which he experiences as an auspicious encounter, making him feel that fortune smiled on his random decision to get off the train at that location. But Ben reflects on the degree of freedom he experienced in the past when he travelled about and made spontaneous decisions about his destination; he explains that he does not now get out or get away much:

Used to make decisions on trains, used to but I don't these days because I don't get out, get away much. Because I lose track of what, um, people keep a track on me with a computerised record, which is not where I am at at all and I have asked them take me off computerised records (Ben: 252-255).

Psychiatric services and other authorities hold information about Ben and this makes him feel uncomfortable. He expresses a feeling that he is being tracked or observed by this systematic recording. This feeling inhibits his sense of freedom, placing a limit on the spontaneity of his decision-making.

Chris also made spontaneous decisions about wandering. He developed a relationship with a woman and planned to marry her, but he could not find employment or accommodation. So they split up and Chris moved back to his parent's home:

I'd split up from my fiancé and moved back in with my parents, and, um my dad was quite a violent guy, a big guy, a big beefy guy, so of course the the slightest little argument he'd he'd expect to to stand toe to toe and sort it out with fists, and that's where my mental health really started to go downhill (Chris: 78-82).

Moving back in with his parents was difficult for Chris due to the aggressive and violent behaviour of his father. He uses a powerful expression; 'standing toe to toe,' and this graphically illustrates his father's intrusion into his space. Chris explains that his father would turn the slightest little argument into a physical confrontation and this led to a decline in Chris' mental health:

I started getting delusional and psychotic, just because I was living un living under a roof where that sort of thing was going on... I think, my parents said to me one day; "You know you you need a doctor." And I just refused and said; "There's nothing wrong with me you know it's the way I'm being treated, in this in this this environment." (Chris: 86-93).

*One day um, after after an argument with my dad and a fight, I just just left the house, in the middle of the night, walked around for a while, got on a train and ended up in ****, so basically sort of homeless in a town I didn't know (Chris: 104-107).*

Chris felt that he was put under pressure to accept medical treatment, but in his own understanding his difficulties were an outcome of conflict in the home. However he did not dealt with this in an organised manner, but just got up, left home and got on a train without any planning or forethought. He spontaneously travelled to a town

which he had not visited before, living on the streets. He explains that when he came to the attention of mental health services, his father collected him and took him home.

Chris struggled to find direction in life and he would; *“Flit from one job to the next, um, I was always looking for the right sort of job.”* (Chris: 146-147). Chris describes himself as ‘happy-go-lucky.’ He explains that the only things he took into consideration, when making choices, was the likelihood that he would have a good time and whether he had enough resources. He also explains how at that time he only made one significant commitment to another person and currently, he has a relaxed approach to life:

I was very happy-go-lucky as a as a young lad, um, and think the only decision I really took, carefully was getting engaged, um, everything else I would make a decision as to whether it would give me a good time or whether I had enough money in my pocket to go and do that (Chris: 130-133).

Because all of my working friends that’s what they like to do at the weekend, um, I’ll bring a little I’ll bring a few joints along as well and we’ll share a few beers and a few marijuana joints, um, and don’t really plan anything day to day, not nine to five Monday to Friday (Chris: 686-690).

Chris lives for himself in the moment, not sharing decisions, socialising with friends in a manner which does not require any planning. He is clear on this point that his choices are not influenced by other people; *“No I made the decisions just on, on, just by myself.”* (Chris: 177). But it is not so clear that he chose an individual and

unstructured manner of living, or just had no opportunity to commit to plans, trust other people or work closely with them.

It was difficult for Chris to live with his parents and he was not able to make decisions with them or fit in with their way of being. He reports that when he found himself detained in a psychiatric hospital, this was another setting in which he did not feel he could fit in with the imposed decision-making of others. He describes how he was handed a paper which informed him of his situation and he was distressed to read that ECT (Electric Convulsive Treatment) could be given and he ran for the door:

Um, the very first time I was sectioned, what really scared me was getting handed a bit of paper that said we can legally give you ECT against your will, and that's when I tried to run for the door. I thought you know I thought 'there's no way you're doing that to me, I'm I'm not receiving that as a treatment' and when they, when I was told; "No we can legally do that to you against your will." You know that that scared me (Chris: 373-377).

Then, medication was forced on me, um, and, and I and I lost all control, I'm certainly a control freak, I don't feel I have to control other people, but I have to be master of my own destiny I have to feel that I'm in control of my own life somehow, and being sectioned really really caused me a problem... the door was locked and there was a big beefy staff that work on the ward, to stop you running away and things, um, yeah, so, it took being sectioned took away took away all my all my rights the way I saw it, and and my decision making (Chris: 381-389).

Chris describes how he felt he lost all control; his rights and his decision-making were taken from him. His desire to run away was blocked by men who, like his father, have a strong physical presence. He does not feel a need to control other people but it is important to him to be in control of his own life. So, although enforced treatment in psychiatric hospital is intended to help people gain control over symptoms and manage their lives, this is not how Chris experienced it.

There are similarities in Ben's account as he also finds that the controlling use of mental health law is a real problem for him:

So I want to want to avoid psychiatry completely now and go straight to the future, and the only way that I can do that is to get off this Section 37/41 so that I have a clear view ahead of me because it's all there 37/41 where every you turn, I think Christ I've got to be free somehow (Ben: 677-680).

This 'Section 37/41' is a part of the Mental Health Act, under which Ben is required to accept treatment and to live in one place. He is not comfortable with this and is seeking some kind of freedom.

Laurie also talks about experiencing detention against his wishes in psychiatric hospital and again, for him, this is not something which feels like a mutually agreed form of assistance. He tried to explain that he could not tolerate the side effects of the treatment he was given. In reluctantly accepting this treatment he was actually acquiescing to the pressure of threatened physical violence:

I explained um that um, um they caused horrendous side effects and um, I wasn't prepared to to have injections, um but I I um, at that same time didn't want to um, risk having the crash team come in and sort of beat me up and, hold me down and give me an injection, which I knew knew would be the case if I, refused, injections (Laurie: 393-397).

Laurie was detained and he felt treatment was forced on him. This intrusion is not experienced as a joint decision-making process. How could he feel that he made a choice, when he faced the possibility that workers would intrude into his physical space in an aggressive or violent manner? However, he does not feel that this was the main means of controlling him in the hospital and he also mentions a grinding routine. He provides a vivid account of the homogenised quality of his shared existence on a psychiatric ward, which, he says, has a pernicious effect on people, so that they struggle to maintain a sense of their own individuality, or differentiate their own choices from those of others. Laurie describes how was caught up in the unyielding routines of institutional life. He then paraphrases things he would like to say, but could not:

I think I was um, um part of the um asylum regime it was quite a pernicious sort of effect on many people, um you didn't really have any choice there... cause you can't sort of say; "Right um I'm fed up with the side effects of these injections and I'm fed up with this disgusting food, I'm fed up having to share a dormitory with ten other nasty smelly people, um, I'm going." (Laurie: 362-366).

Although the interventions of mental health services are designed to help, to bring stability, regulation and control, they are experienced by Laurie as intrusive and uncaring. He does not feel human kindness, but says he was subjected to an inhuman institutional system, wearing down his hope for self-expression and personal choice. The decisions which governed Laurie's existence were experienced as a relentless regime in which his human feelings, his voice, would not be heard. He observes that, while other people were starting to establish households and relationships, his life was blighted by periods of admission to psychiatric hospital:

I I'll was was at that age when you you're start to um. establish households and that kind of thing, um establishing relationships and have a partner um, but unfortunately um, um the time, that time was blighted by, my um, period... Obviously you know you can't sort of say; "Well come on marry me, um you know I can still keep living in the male dormitory you know and um, um I can earn one pound seventy pence a week down at the Industrial Therapy Unit." (Laurie: 77-82).

Laurie reflects on his experiences and observes that it was not possible for him to make decisions in the same manner as other people of his age; such as choosing to marry and feels left behind. The quality of Laurie's life in the institution is graphically recalled in his account of the food that he was served; *"They had particularly um, um a, particular way of ruining mashed potato for example, which mashed potatoes were a major part of most of the d dishes they served up, um and I just found it inedible."* (Laurie: 128-134). Laurie eventually gained discharge from the hospital, but a question arises as to why he did not simply give the appearance of fitting in, so that

workers would trust him more and he would be discharged sooner. Laurie describes how he rebelled against the decisions that workers made about his treatment:

I told them again when they were giving me the injection that, I was going to do property damage... I got out of a window in the middle of the night and I smashed a window, um, next, I got brought back... by the police because I was wandering around um, early in the morning (Laurie: 403-408).

As a reaction to the experience of having treatment forced on him, Laurie expressed his resistance and engaged in a rebellious act. However, this is not consistent with life choices he would make in his own right, if he were progressing in his career and forming supportive adult relationships. Also, when he did escape from the hospital, he had no rational plan or means of getting on with his life, but he just wandered around. Laurie's choices were taken away and when he regained his freedom, he clearly struggled to gain a sense of living his own life again.

Is there something significant for these participants in the lack of human care they experience and the random quality of their wandering? Flipping a coin, for example, is a recognised means of making a decision when we cannot be sure what we want. In a miss-match of expectations, participants in this chapter have not only resisted attempts to help them make rational decisions, but Ben and Chris have also mentioned their use of alcohol and illicit substances, through which they have altered their moods, induced states of elation or escaped into mental absence. Chris admits that he has used cannabis partly to impair his decision-making:

I've always used cannabis and, since I was about seventeen anyway, and that's been a big bone of contention with, with most of the staff, even social workers that I've encountered, you know since I was, since I was first sectioned... It will impair my my decision making ability, but that's partly why I use it, it's the same as using alcohol, you know, once you've had a few, you've got to wait a few hours before... before it wears off (Chris: 509-519).

Chris says he is a 'control freak,' so why would he take substances which impair his decision making ability? Well he also describes how he feels controlled by people who hold authority over him. So impairing his decision-making is perhaps a means of evading that authority. These participants can be more certain that the choices they make their own, because other people have disagreed with them. An excessive use of alcohol or illicit substances might be thought of as a kind of self-sabotage, so that decisions are not under one's own control, but also, not under the control of others. It is perhaps more tolerable to not have any control than to be controlled by other people.

In the oppressive routines of institutional life, or in mundane work roles or in the impoverished life of unemployment, no new opportunities or possibilities are experienced. Escape is, therefore, a priority in either physical or mental forms of flight. Ben, Chris and Laurie might have tried to subvert or hijack the rational plans which others have set in place, agitating and confounding the established system. In the spontaneity of this rebellion, unstructured decisions might bring fortuitous outcomes, like coffee and sandwiches on the seafront. Like the throwing of dice, the randomness of these actions opens up the possibility of chance occurrence; good

fortune or bad luck both remain possible, so long as the dice are rolling. However as Ben observes, everywhere he looks in his life he sees the limitations placed on him by mental health law, Chris finds himself encountering big beefy men who stand in his way and Laurie feels trapped in a pointless institutional routine which drains his sense of self-determination.

Understandings which are expressed in professional knowledge systems and forms of legal guidance are influential in this chapter, where regulation is imposed on participants. There is a sense of oppression, where they are under the threat of physical restraint, though which the injection of sedating treatments is forced on them. Vivid accounts are provided of intrusion into a person's space as an intimidating form of interpersonal pressure. A need for separation and distance arises as a core experience, such as that which is experienced when wandering. Participants fail, therefore, to invest in relationships and rarely made commitments to others. But wandering does not lead to constructive plans or actions and freedom is only experienced in impulsive choices, in meeting immediate needs or desires. While their contemporaries made relationships or progressed in their careers, these participants are caught up in difficult interpersonal encounters with mental health services and are left behind.

2. From mistrust to paranoia

In the experiences described in this chapter, participants can recognise with hindsight that they have 'situated choices.' Their decisions are influenced in part by their own desire to be in control of their lives, but also prompted by the containing or limiting actions of people in authority. They are not able to trust and become estranged from

others, focusing more on their own insular thoughts, beliefs and desires. They miss out on life opportunities by being caught up in cycles of entrenched conflict and a loss of liberty, which they try to avoid by wandering or living on the street. When they reflect on their lives they wonder how things might be if not for the intrusion of others. These intrusions are not experienced as reasonable, or rational, or caring, but are often viewed as a personal and vindictive denial of their rights.

The ability to trust others is important in the negotiation of mutually agreed decisions, but participants in this chapter talk about their determination to make their own choices and they somehow miss out. Laurie, for example, suggests that he would now have a successful career, owning his own home. He describes how people were questioning him, wondering why he was not fitting in with the common expectation that he should attend for work:

This time um, it wasn't just something like um living as a vagrant um, or living in my car or something like that, it meant that, lost the um, the house the house got repossessed when I stopped paying the mortgage on it, I got made redundant from my job, um, I was getting quite unwell and people were questioning; "What what are you doing not working and things?" (Laurie: 239-243).

Laurie had people around him who were concerned that he was letting things go in his life. However, he did not attend to their questioning and he stopped paying the mortgage so that his house was repossessed. Perhaps his decision-making was influenced by a desire to be free from the intrusion of others. After he endured the routine of hospital life, he wanted to be free, for example, from the requirement that

he take a humiliating form of treatment. But the cost of this freedom meant that he must remain homeless.

Because the medication was invariably given by injection, which was a very humiliating sort of procedure, and also it caused horrendous side-effects, um, and um therefore I would drop off the medication (Laurie: 221-224).

You could have your freedom, and and the bliss of not having the injection um, you could have your freedom but it would usually come at the cost of vagrancy and, um running out of money um, um and um having nowhere to live um, that's what my experience was anyway. (Laurie: 369-373).

The only freedom Laurie could experience, at this time in his life, was the freedom to live as a vagrant. He could not trust these people and felt that the only way he could hold onto his liberty, when not taking psychiatric medication, was to avoid them.

Chris also describes a life in which trusting people was difficult. An escalating cycle of mistrust is prompted in which workers increasingly questioned the safety of Chris' decision-making and he increasingly tried to evade their scrutiny, avoiding their interpretations and seeking his own space. Like Laurie, Chris did not trust the people who were trying to help him and he was avoidant. He claimed to be taking treatment when he was not:

I didn't trust the doctors I was working with, because they were doctors that sectioned me in the past, and and and from my point of view, took my rights away (Chris: 604-606).

I'd take the meds until I experienced side effects, um, I would just, just basically lie to my doctors and say; "Yeah I I'm taking them." Um, then after repeated admissions cause, because I wasn't taking my meds I would crash quite regularly, so, and I'd end up sectioned on the ward again (Chris: 56-60).

Chris could not trust mental health workers. They took his rights away in detaining him, because it seems, they could not trust him. He was not honest about his failure to take prescribed treatment. This mistrust brought about a cycle of admissions to psychiatric hospital. However he suddenly realised that workers were trying to help; *"I had a sort of eureka moment, and and realised that, that OK these people are trying to help me."* (Chris: 612-613).

In contrast to Chris' realisation, Ben continues to feel that his freedom is taken from him for personal and vindictive reasons. He describes a tribunal hearing at which he could appeal against detention under mental health law. He does not however view this as an impartial legal process. For Ben it feels as if the officials and doctors have a personal vendetta against him:

No way, he even took the piss out of me, the guy in the middle of the desk, he he said; "I know how you feel, don't you long to feel free... I know you feel free but we are

never going to let you be.” Whatever! Psychiatry is a two way thing not a one way
(Ben: 56-59).

In Ben’s experience, there was no fair process of considering evidence or making balanced judgements; he felt this court process was just a peevish denial of his right to be free. Ben wanted a negotiation in which both parties have a say, but he experiences his psychiatrist as someone who is not playing fair; *“So I thought to myself games? games are a two way things, this isn’t two way it’s one way, he’s not a cowboy he’s a fraud, he’s less than a cowboy.”* (757-758). His opportunity to communicate in these encounters is reduced and he is understandably concerned about his ability to get his needs met. He does not trust this psychiatrist and he baulks at the possibility that he might not be able to explain what he needs as he gets older:

I am getting old and I don’t want to be on the treatment when I get old, because I wont be able to explain to them what I need, and they can’t say they’re right because I know there’re wrong. I have watched them treat lots of patients. Lots of mistakes made and nobody makes any fuss over it, well I do, I don’t want someone having to wash my arse and give me a bath I don’t want any of that crap, I’d rather be fucking dead (Ben: 385-390).

Ben does not want to get old and infirm so that must rely on other people to care for him. He is not comfortable with the prospect of thoughtless neglect in an institution. From Ben’s point of view, he is trying to engage with people who manage his care and treatment. He is trying to understand what they are about. But he does not feel he is being treated as an equal adult person. He is aware that files are kept, but he finds

that workers will not discuss the understandings they use in their decision-making processes. Perhaps, the more they reassure him, the more suspicious he becomes:

I said there's got to be some files on me but; "No we don't keep files." But there's lots of files, they write all their stuff out every day they've got mine so why don't they let me see mine? (Ben: 45-47).

Ben is asking a reasonable question and it would be a matter of concern if workers do not take time to explain their record keeping and allow him access to it. However, in Ben's experience, workers are not concerned about his rights, but are trying instead to impose their views on him:

Even though they appear to be friendly it's is all a front really, underneath it all it's strictly 'one god,' I I really do wonder if they do know, or listen to anyone there, beyond their picture of what the person should be (Ben: 895-898).

Ben does not agree with the interpretations of the workers who manage his care and treatment. He dismisses any attempts workers make to engage with him and he is generally mistrustful. He might be referring to the psychiatrist as 'one god;' the only person anyone listens to. He does not find their picture of what a person should be meaningful and he resents the manner in which they can exercise authority over him. He uses insightful humour to express this; *"Just because you are paranoid it doesn't mean they're not after you [laughs]."* (Ben: 934). His point is that even if his mistrust were caused by a biological illness, this does not mean that other people are always trustworthy.

Chris provides another detailed account of how he struggles when people hold authority over him or impose their views in close proximity. He recalls that he made choices from an early age in response to his feelings and he does not want other people to impose their will on him. He describes one of his jobs as difficult and he did not get on with his manager:

Yeah I realised at a very early age that I don't deal with stress particularly well, so I had this horrible job, where the manageress hated me, and I would just wake up every morning and think 'oh God I've got to go into work again,' and um, that's I think that's where I started to get ill... so I started to lead my life in such a way that I didn't have to deal with stress, um, I started farming and I took a farming job, just working in the fields with the sheep, and you know things were OK for a few years, yeah, it wasn't till I moved back home, in with my parents, after having spent a few years doing my own thing that I really got ill (Chris: 228-239).

Chris struggled with the routine of attending for work. He woke up every morning distressed, so he took action by changing his job, leading an isolated life so that he did not deal with people. However, while he enjoyed a kind of freedom for a while, he was then distressed when he had to return to live with his parents. He goes on to talk about a time when he moved from a kind of supported accommodation into his own privately rented flat:

What was wrong with my old house? it was a little small, the, the support was kind of claustrophobic sometimes, I was getting a lot of support there, certainly in the

beginning, um, and the the new flat I was offered was a little larger, um, in a in a decent area, all, right in the centre of town (Chris: 355-359).

Yeah, some of the neighbours are a bit of a problem; I've just got to keep them at arm's length (Chris: 265-266).

Chris likes his own space and the requirement that he accept help from mental health services, in 'supported living' accommodation, made him feel claustrophobic. For Chris, this is linked perhaps with his experiences when standing 'toe to toe' with his violent father, or backed into a corner:

If you back anyone into a corner they will fight and that's what used to happen to me, they they backed me into a corner, I'd start arguing and and shouting my own corner, and then of course I was a danger, as soon as that happened I was a danger and then I'd be sectioned (Chris: 485-488).

Chris' desire for space and his wandering are then, in his experience, not behaviours which are caused by mental illness, or his own uncontrolled aggression, but are perhaps a very human response to having people hold authority over him, his unfriendly manager at work, his aggressive father or the controlling intrusion of mental health services.

This is similar to Ben's experience when he feels that a psychiatrist intruded to the degree that he got under his skin. This psychiatrist was not, in Ben's view, acting to help him in a 'two way relationship,' but was working in the interests of the police.

He was gaining evidence in a case against Ben, rather than expressing love or care towards him:

He got under my skin and I could physically feel it, I felt and it took some time to shake it off. There was nothing nice or doctoring speciality or loving or caring, you know he thought he was he was a glorified police, collecting files for other people as far as I could see (Ben: 716-718).

Ben's feeling that a psychiatrist 'got under his skin' is linked in his experience with a lack of love or care. From Ben's point of view this psychiatrist was working with the police and the courts supporting legal action against him. Ben originally accepted help and support from mental health services because he thought workers cared about him and would help him, but this is no longer his view and he does not want to be involved with these services; *"I was interested some time ago but I am not now, psychiatry has become too clinical, it's not the same as it was years ago."* (Ben: 675-677). His experience of mental health services in general causes him to feel angry and resentful. He does not feel he is included and has a sense of injustice, linked to those feelings of mistrust. So Ben feels that mental health law can be used on a whim and he assumes that his psychiatrist will take control, or not, for purely personal and malicious reasons:

Well they can, take me off the Section or leave me on it forever isn't it. I am never going to forgive him, ever, there's no ways about that, that man was nasty, that psychiatrist (Ben: 712-714).

This is a central experience for Ben, in which he feels decisions are imposed on him for no good reason. He is subject to the arbitrary will of a person in authority, rather than having a two way negotiation. Ben does not think about the decisions that the psychiatrists makes as an aspect of an institutional system. For Ben, along with Chris and Laurie, the decisions of mental health workers are perhaps just another random intrusive experience in lives in which they already struggled to feel in control.

Participants in this chapter all experience the interventions of mental healthcare as intrusive and distressing. There are periods in their lives in which they do not meet workers as equals or negotiate decisions with them. The knowledge systems of mental healthcare diminished their sense of individual expression, while the rational processes of institutional decision-making do not make them feel cared for. Their reaction against this denial of their will, perhaps, pulls them into childish or rebellious behaviours, with feelings of fear, anger and resentment. While resisting their need to depend on others, these participants are not able to take control in following their own plans and find themselves bound even more tightly into imposed forms of control.

While an imposed closeness to others in an institution is well meant, it is an uncomfortable experience, which is for these participants quite unhelpful. It is in this mismatch in expectations that they make choices which others find irrational. They are not investing their efforts in building relationships, careers or paying mortgages. Instead, they find themselves either under the control of others, or wandering in a manner which might appear to be random, seeking meaning in the chance occurrences of their lives.

3. No right way to be

Participants in this chapter hold onto their own idiosyncratic beliefs, giving the troubling events which they encounter meanings of their own and resisting the realities which other people try to impose on them. Although they now feel they missed out and they regret their loss of relationships, jobs and homes, these participants are not able to fit in with common expectations. They experience themselves as different and separate, not ever being right in the eyes of others, while also feeling intruded upon. In their own interpretations they feel hounded by people in authority, while in resisting the meanings these authority figures imposed on their actions. Often, their opportunity to express agency is lost in a confusion of interpersonal conflict and control. Their efforts to be separate only create a more complex experience of being enmeshed.

Chris felt that his control was taken away and he was not able to choose to marry, or choose where to live. He does not feel involved in decisions about his care and treatment, finding himself held under mental health law. He might therefore be able to take some control back by suggesting that he would not have wanted to be involved anyway. He explains that in his youth he hated society, not wanting to be part of it, wanting to opt out. He suggests that his hatred was not sociopathic, but a strong dislike of many stereotypical signs of fitting in with society:

I used to be a bit of a sociopath when I was younger, I hated society I didn't want to be a part of it, um, I wouldn't say that was a clinical illness I I never got diagnosed with with that sort of trouble, but I always wanted to opt out of society, I didn't like

the nine to five, having to wear a suit to work, having to be clean shaven with short hair, and shiny shoes, you know [laughs] (Chris: 812-816).

Chris' dislike of society, he believes, is not a psychiatric condition and he is a sociable person: He mentions that he is often spending time with friends. He does not, however, experience a desire to compete in society, or to adopt behaviours associated with ambition, or fitting in. But he is older and starting to wonder how things would be for him now, if he had more often followed social conventions; if he agreed, for example, to marry his fiancé:

I wish I'd done things differently, and got married when I was young, and and had kids when I was young, um, so yeah I do, I guess I do yearn for those things sometimes (Chris: 805-807).

Chris can see with hindsight that he could have made decisions differently and he feels he is missing out. Laurie has similar regrets and feels that being held in hospital, or living as a vagrant, blighted his life, denying him the opportunity of marriage; while he also lost career opportunities:

Working as a clerk in the City and, living in that house um, um, um and um, I would have um, had a few promotions since then and I don't know where I'd be, um, in in that sort of um, life-style right now, um, but um as things transpired um, um I got um, quite ill, and I became quite deluded, didn't have um, um any medication to stop me being deluded and paranoid and um, after I lost my house I was five years homeless living in, bus shelters and um under trees (Laurie: 247-252).

In Laurie's experience, he is not now living the life that he might, if his mental health problems were adequately treated; *"I live in Social Housing, um I don't have a regular job, um and um anything else to do with my welfare um, um all always involves someone from the Day Centre."* It is difficult for him to make decisions about his situation now, when he does not feel his life is how it should be. It is paradoxical therefore that Chris chooses activities which would limit his opportunities; he smokes cannabis most days for example, and Ben also mentions his use of illicit substances. There is a sense that both Ben and Chris want to make independent and separate choices. Chris did not want to be part of society, while Ben also believes that from a young age he was different from others. Ben suffers distressing experiences in which his father intrudes into his consciousness. Although his father died many years previously, Ben still does not feel able to escape from him:

I'm haunted by him, he won't leave me alone, I don't want to know, it's it's all big, big bloody flash hap pappy I don't, I don't want anything, to know about, to know about him at all... Phew I wish he'd let me alone yeah... I'd like to be broken off completely from all relationships (Ben: 453-460).

Ben might only be referring to his father when he says he wants to be broken off completely from all relationships, but he is uncomfortable whenever anyone holds authority over him.

Chris felt stressed when working with a manager who, he believed, did not like him, and he was not comfortable when he returned to live with his parents, where he

experienced a lot of conflict. In a similar manner, Ben did not feel able to understand his family and he did not feel he could get on with them:

I couldn't get on with them in any way my whole ideals and views on life were totally different to theirs. I couldn't understand it, I thought to myself 'come on', you know, I mean, I've slagged them down and this that and the other, but you do that when you are young (Ben: 552-558).

Ben found that his ideals and his views on life were different from those of his family. He suggests however, that it is commonly the case that young people take a critical attitude towards the views of older generations. But he feels different from other members of his family; *"I've always been the black sheep of the family."* (Ben: 537) and he now struggles to get on with mental health workers. He believes, for example, that he must agree with the decisions they make about his life, because they get uptight if he does not follow their will; they make demands on him. He is sensitive to their emotional dispositions but does not feel entitled to experience his own feelings. He is concerned for example that these workers will reduce the amount of Procyclidine he is given, which is prescribed to manage the unpleasant side-effects of anti-psychotic medication. His own emotional responses are viewed as problematic, so that if he were to feel too happy or too sad, offence would be caused:

I have to agree with them or they will start getting uptight wont they and start making demands, all sort of things like; "We'll take some Procyclidine off you, you're getting too happy or too sad." Or whatever, I can't be too happy, I can't be too sad, I can't

be too medium really without somebody offending me; getting offended (Ben: 402-405).

Ben feels his emotions are under scrutiny; there is no right way for him to be and he was held in hospital wards where notes are recorded on his emotional and psychological state. This objectification is experienced as an inequality in the use of power in his relationships with mental health workers. His response to this is to feel that he has nothing to say:

I've got nothing to say, but it's OK. If I'm too medium then even that is a bit wrong, not quite well in the head, if I'm too high I'm wrong, done wrong, too low and I'm wrong, too medium and I am still wrong, so, I just go and tell them I'm a stone really, drop into a bubbling spring and carry on, sink beneath their wisdom like a stone (Ben: 1181-1185).

Ben uses expressive language in talking about the understandings imposed on him by psychiatric workers. There is no right way for him to be within these knowledge systems. He is somehow wrong when his emotional state is too high or too low, but is still wrong if his disposition falls between these states. Ben's emotions are experienced as unconnected with his social relationships or out of place somehow. He is clearly feeling anxiety, fear and anger, but these experiences do not pull him into taking constructive action within any kind of shared understanding. This highlights again that significant mismatch which develops between Ben's understanding of himself and the understandings of psychiatric services, in which his emotions are seen as symptoms of illness. This mismatch is also illustrated by the manner in which

Chris experiences a situation in which he was expelled from college. He describes how he always wanted to become an expert on the chemical processes that occur in explosions. But then it appears that he believes he actually developed this expertise. He gives information on an experiment to a lab technician:

The lab technician said 'oh what's the experiment?' So I just said well you mix the two chemicals, and that's how you make a hydrogen bomb, is is with heavy water and Deuterium and Tritium... I saw a flash one day and the and the fire alarm rang, and the next day I turned up to college they made it very awkward for me, so I think they tried to repeat the experiment (Chris: 171-179).

Chris believes a nuclear explosion occurred at the college. This idea might be thought to be farfetched but it is central to Chris' experience and perhaps he is associating his understanding of himself, as someone with a significant degree of expert knowledge, with the manner in which he was treated by people in authority at the college. He might wonder, for example, why they made it so awkward for him. Rather than understanding himself as devalued and excluded, Chris saw himself as having a degree of knowledge which would cause people in authority to be concerned.

Chris gives his own meaning to events; seeing himself as subject to persecution because of the dangerous expert knowledge he possesses. He assumes that people in authority are trying to control or undermine him because of this. Chris's feelings of anxiety are then grounded in something very real for him and the claim that he is suffering from mental health problems is, in his view, just another means by which agents of social control seek to discredit his ideas. Then, when Chris looks back on

these events and thinks about his responses to them, he now believes to a degree, that he was mentally unwell. He associates these experiences with his concerns about control and authority:

That's how my illness works I I get delusional and psychotic, um, and it can be about anything, it's it's usually about security services and, people who have more power over my life and my destiny than I do (Chris: 452-455).

Chris describes a need to be master of his own destiny. The fear and anxiety he feels, in relation to a possible loss of control, are significant factors affecting the choices he makes. These experiences are expressed, he suggests, in the manner in which he becomes delusional and psychotic, usually about people who have power over him. Chris will, therefore, read meaning into events which other people would not, because he is experiencing the actions of others as potentially intrusive or controlling.

Ben also reads meaning into events which others might dismiss as coincidence. Perhaps he is experiencing a need to manage unpredictable events and he speculates about the date of his own death. He recalls that he was served a meal in which his mashed potatoes appeared in the form of a number:

Seventy two, I think that I'll die when I am seventy two, I've seen it in my mashed potato on the side of my plate, two, I said what does that say, seventy two, seventy two, I said I bet that is when I die, seventy two years old, maybe and I just left it. (Ben: 384-397).

Ben 'thinks' that he will die when he is seventy two; 'maybe.' So this is perhaps just a kind of hypothesis. While he is clearly looking for meaning in events in a manner which would not be thought rational, the need to predict the uncontrolled nature of significant life events, such as death, is very understandable. But his life experience more often places him at odds with others and his interpretation of events is not often shared. Like Chris, Ben has ideas or experiences which are unusual. He describes how he sees ordinary people who are dead walking in the street and he speaks with them:

I see ordinary people that are dead walking down the street and I say; "Hello" and they are using the same name and they say; "Yes that is the right one" so I think to myself yes, we are all in this together, but I can't move into the next life with this silly burden hanging over me, cause I've got to carry it and carry what, I don't know, I had no intention to do him any harm or anyone any harm so what am I carrying on me? (Ben: 1061-1069).

Ben explains that he was arrested for assaulting a man in the street. He thought this man was his dead father and he claimed to be acting in self-defence. His freedoms, however, are now limited and he is currently required to take treatment under mental health law. But Ben does not accept that he intended to cause harm and feels that the requirements of mental health law are like a burden he carries. Ben is alone in his belief that he did not commit the crime, facing the united front of the police, the courts and the psychiatric care system. Ben is isolated and made different. His idiosyncratic ideas about seeing dead people would perhaps only isolate him more.

Although Ben says ‘we are all in this together,’ no one, it seems, is trying to share these understandings with him. It is difficult therefore for Ben to share a sense of who he is as a separate person from others, because he does not experience himself as making significant choices of his own. There is, again, that sense that he is not in control of his life and he believes, for example, that workers manipulate his behaviour by using hypnotism, as well as by injecting him with psychiatric medications. He recalls having asked about hypnotism and requesting that a worker uses this on him, but he cannot remember what happened next:

I said; “Right that’s it you can start on me,” and I said; “Do do you do hypnotism” and she said; “Yes, but not very well” and I stopped there, I can’t remember what happened next (Ben: 800-802).

Woohoo, you know what I mean, what comes in that needle there, that is drug induced schizophrenia. It’s the key, it’s it’s it’s the fucking jab in the first place and all these side-effects are not side-effects they are ‘the effects’ [laugh] (Ben: 617-620).

Ben interprets a gap in his memory as a sign that a mental health worker controls him through the use of hypnotism and he also entertains the possibility that the medication which he is forced to take induces symptoms of mental illness. He suggests that it is the anti-psychotic medication that causes schizophrenia. He also claims that experiences which are termed ‘side-effects’ are intended effects. So it would be difficult to convince Ben that nothing actually happened when he asked about hypnotism, or that workers are not trying to control him by requiring that he takes medications, or that his agency is not affected by these interventions. He does not

trust people and might perhaps observe that they would deny everything. Ben's choices are clearly, from his point of view, quite rational and reasonable.

Again Chris and Laurie have similar experiences. From Chris' point of view, he is able to recall the logic with which he made decisions, weighing up his options, but is now aware that his belief system at the time had no basis in truth, so that he made irrational decisions:

I suppose once I started to get ill, I was making bad decisions, because I was delusional and psychotic, so I would think, that with belief system that I was using, I would think that I was coming to an informed decision, and it proved to be irrational and no basis of of of truth in the decisions I was making (Chris: 133-137).

It is interesting that Chris made decisions at one point, but then with hindsight, he could see that these decisions were not correct, because they were based on his previous misinformed state. Chris must accept an interpretation in which he now understands himself as having been mentally ill.

Laurie also observes with hindsight that when he did not accept psychiatric treatment, he did not make good decisions, although these seemed to him at the time to be reasonable choices; *"I would um, rapidly get ill again um, and um I would make some very unwise decisions."* (Laurie: 224-225). Although they resist the interpretations of others, the inconsistency of their being across time requires that Chris and Laurie recognise the irrationality of their actions. But Ben can continue to dismiss this lack of an essential rational self, by suggesting that he is not in control of his actions, due

to the intrusive intervention of mental health services. In his experience, workers take control of his actions, by keeping computer based records, imposing hypnotism and medication, thereby undermining his autonomy and limiting his freedom.

Participants in this chapter describe intense emotional responses to events in their lives. However these responses are divorced from shared understandings, so that each of them is estranged from the people who would otherwise help and supported them. The emotional dispositions, that they find themselves experiencing, prevent them from fitting in with others. They are not able to find a place to be in society in which their emotions enable them to co-operate with others. But, no matter how uncomfortable contact with people in authorities might be for them, reliance on others seems to be inevitable. The more they resist; the more dependent these participants become.

When participants have no sense of connection with others, they develop their own means of understanding their lives. They avoid, for the moment, common forms of responsibility in lives in which they do not make commitments, but this does not bring them the freedom they desire. Holding onto their own beliefs, in conflict with others, does not enable them to find a place to be within society. Their experience of resisting the meanings that others have tried to impose does not give them an active sense of self. They more often experience themselves as subject to oppression. Then, in understanding themselves as different or opposed to common forms of being in society, these participants do not feel that they are carried along in a flow of shared meanings. Their experience is rather that of an object like a stone, which sinks beneath the constant babbling of contested meanings.

Conclusion

Participants in this last chapter make individual decisions and they experience themselves as somehow at odds with the expectations of others, while it is also clear that interpersonal emotional processes have a strong hold on them. Their choices are founded on their emotional disposition, while that emotional state is also a response to the behaviour of other people. There are, for example, strong feelings of fear and anger, when mental health workers put limits and boundaries in their way, which these participants experience as a form of attack, or a personal and vindictive kind of abuse. In these experiences they feel that their independent will is taken from them, when they are held in impoverished institutional environments, with oppressive routines, in which they are treated in a humiliating manner or when their wandering is curtailed.

A sense is gained of the rejection of everyday conformity, in a desperate need to be separate or contrary. Living a vagrant life-style is preferred over the experience of being powerless in the routines of an institution, or in employment, or paying a mortgage. Different interpretations are contested in these accounts, as psychiatric treatment is forced on participants, with the apparent assumption that they resist because they 'lack insight;' failing to accept a biomedical understanding of their difficulties (Dolson, 2005). While in their own view, these men are making reasonable choices in living on their own terms (Erdner, et al., 2005). Fear and anger are human responses to experiences of powerlessness in the face of authority and a strong urge to escape from the influence of that authority is described. Participants seek distance from others and they fail to develop intimate adult relationships or maintain employment (MacDonald, et al., 2005).

The decision-making processes described in this final analysis chapter bring us back to the perspective of the individual actor. The three participants who contribute to this chapter all make insular decisions, failing to commit to relationships, preferring not to engage in shared enterprises. It could be assumed that these behaviours are caused by traumatic and intrusive experiences, by a lack of opportunity, where accommodation, adequately paid employment or other resources are not available. However, people are free to respond to experience in different ways and behaviour is not determined in a simple manner (Frankl, 2004/1959). Interpersonal emotional processes are extremely complex and often associated with the particular meanings people attach to their experiences. Participants in Chapter 5 speak of sometimes accepting the guidance of others. But in this chapter, participants seek to avoid the guidance or control of others. They seek new experiences, opening themselves to chance events and giving their lives meanings in their own idiosyncratic manner.

The experience of psychosis can make people feel picked out and made different from others (Erdner, et al., 2005) and Laurie describes how people were questioning him. However, mental illness is not consistently spoken of as something which is separate from a person's wider life or their sense of self in spiritual or moral terms (Kinderman, et al., 2006). Symptoms, treatment and associated side-effects are a seamless experience; an embodied state in which these phenomena are not differentiated (McCann & Clark, 2004). Participants find meaning in events, therefore, in a manner which other people might dismiss. But the need to feel that life is more than a sequence of random happenings, or that one's emotional or psychological response to this is more than a symptom of illness, is very understandable.

Participants in other chapters describe how they often struggle to feel in control. They find themselves in ambiguous situations, which could be given different interpretations, so that the meanings of their decisions and the manner in which they are understood can switch about in an unsettling manner. Some participants are confronted by unpredictable demands on their limited time and resources, also prompting uncertainty, while others speak about extreme changes in their moods, so that they cannot account for the choices they make. It is difficult to draw a consistent sense of self from these experiences and participants often feel they are being watched. Participants in this chapter also felt they are monitored and their choices placed under scrutiny. Ben and Chris actively seek to change their moods or inhibit their rational decision-making, or wander in an unstructured manner in which others cannot impose regulation. The use of substance might be thought of as a ‘controlled loss of control’ as means of expressing an alternative social identity, or making different subjectivities possible (Measham, 2002).

Participants in this chapter are not able to trust others or build relationships or settle to working careers. So while participants in Chapter 7 cling onto established practices, guided by shared understandings, participants in this chapter take refuge in their own individual interpretations and there is no mutually accepted understanding of who they are. The subjectivity and narrative identity of participants is again in dispute, where they hold fast to their conflicting interpretations. Rather than seeing their position in society as passive or excluded, Ben and Chris define themselves as actively rejecting social norms or expectations (also discussed by Scanlon & Adlam (2008)). Meanwhile, rather than seeing themselves as oppressive, participants in the previous two chapters feel they are trying to meet needs and manage risks. Sartre

(1969) observed how people can find themselves alternatively in the different positions of an object defined by the meanings imposed by others, or an observer making others the object of these meanings. It is argued that the possibility of freewill is established through our emotional response to others (Strawson, 1960/1993). The expression of this freedom can then be used to define who we are and in his discussion of these processes Paul Ricoeur describes two different kinds of self;

“Idem-identity; sameness over time related to character, habit, a spatiotemporal self-sameness constructing a disposition that enables us to say this person is this particular person” and “Ipse-identity; a keeping faith within interactions, holding firm to agreements, consistency in one’s dealings with others.” (Mulfoen, 2002: 88).

When the accounts given in this chapter are compared with those in the previous two, it is clear that some people have a consistent identity based on psychiatric assessments which define symptoms, personality traits and typical presentations in a psychiatric case history; they are thought of as in need of protection, support, or containment. Other people enter into commitments to meet these needs. These workers are then only thought to be a consistent self when they dependably deliver these interventions. However, these means of having an identity, or experiencing an existence, are not the preferred means of giving life meaning for either group of participants. There are ideological understandings at play in this setting, imposing uncomfortable meanings on all of them.

Participants in this chapter have described how they have, at times, attempted to stand outside of society, while mental health services make assertive efforts to engage

people who take this stance (Wright, et al., 2011). But the apparent friendliness of these workers is not taken by Ben as a foundation on which trust might be built. Participants are clearly aware that workers bring assumptions and interpretations which they seek to impose, and there is a desire to hold onto their own views, formed from their own experiences. Although their ideas would most likely be dismissed by others as delusional, their beliefs make sense for them, at the time, as rational ground on which to found their decisions, connected with their goals and ambitions (Rhodes & Jakes, 2000).

While participants in Chapter 5 found that shared understandings enabled them to manage their unwanted emotions, or contain their decision-making processes, Ben and Chris have adopted individual views, giving personal meaning to these aspects of their being. In explaining their experiences of oppression and powerlessness, they adopt ‘conspiracy theories’ and other common means of making coincidence meaningful (Cromby & Harper, 2009; Harper, 2004). They do not then need to accept the logic of professional understandings, in which they would be required to take responsibility and regulate their moods. But this prevents them from finding a place in society, or a right way of being, within the understandings of others. Uncomfortable interpersonal emotional processes continue to trouble these participants and for Chris and Laurie, adopting a biomedical understanding of mental illness is the only option they have, other than continuing to resist the meanings which others impose.

In concluding this final analysis chapter, an attempt is made to draw threads together across chapters and this work continues in the following conclusion chapter. A sense of self emerges when people find themselves in conflict with others and this is placed

in contrast with the inconsistency people can then experience in their decision-making across time. There is an expectation that a person should make sense in an essential and pre-formed manner, which can be lost somehow when their choices are the same as those of others, when they follow guidance and advice. There is also an unsettling experience of understanding one's self and one's choices in a particular manner, which is then found to be at odds with the understandings imposed by someone in authority. We are suddenly cast in a different light and we might assume that this is revealing our true nature, only to find that a different interpretation will be imposed at a later date. Our emotions are stirred up in a manner which underpins this difficult sense of social churning. We are driven by the logic of different and constantly changing means of understanding, in which interpersonal pressures demand different actions of us. So, under the scrutiny of an ever watching authority; we are too caring, or neglectful, we are too high or too low; we are hiding in bed or spending too much money, over involved or distant and unemotional. Psychiatric medications might help us to manage the distress of this emotional turmoil, cutting us off from feelings of attachment or repulsion, but the regulated self this creates might not be a person we recognise as our self.

Chapter 9: Conclusion

Introduction

This study has brought participants together so that we can hear their different accounts in which the causes of mental health problems are contested. This is not just about holding different opinions, as various rights, responsibilities and other expectations are implied. When understandings are imposed a person's sense of self or social value can be undermined. This complexity is dealt with by setting these interpretations aside and attempting to include the full experience of all participants. An attempt is made to understand their diverse lives and their encounters with each other by attending to the common existential dilemmas we all face in making decisions.

A hermeneutic phenomenological approach was employed, which is also informed by ideas from existential philosophy. Interviews were conducted with participants who are involved in mental healthcare. People were included who are diagnosed as suffering from mental health problems along with support workers, family carers and professional workers; although many participants belong to more than one of these groups. Audio recordings were made of the interviews and these were transcribed. The transcripts were approached using an initial close reading of the text, moving on to the use of descriptive annotation, to form a holistic analysis. Selective questions were asked leading to tentative headings. Transcripts were then brought together in groups to develop an integrative level of analysis, as reported in the previous chapters. This chapter continues this integrative analysis.

The chapter starts by presenting findings and then by considering the implications. The thesis is then evaluated. The conclusions that are drawn in the thesis are discussed in four sections. The first and second sections start to consider the existential nature of our decision-making, introducing an analysis of our existence in modern economically advanced societies. In the third and fourth sections the chapter moves beyond a description of a series of human experiences, to observe patterns in the data, employing further insights from existential theory. Core aspects of being are examined such as our existence in time and place along with our embodiment and our relationships with others.

Participants in different analysis chapters give accounts which complement each other. Similar scenarios are described from conflicting perspectives. Meanings are promoted and contested, enabling a form of understanding to emerge which challenges simple or reductive models. Experiences can be viewed as an aspect of complex multi-faceted encounters, in which participants are both embodied and situated in social situations. It is not helpful to reduce our understanding to narrow models of disease, personality disorder or social vulnerability. Decision-making depends on processes acting at all levels and choices are individual, interpersonal, or group based, all at the same time. Extending oneself into a decision-making process is therefore enabled by many different processes coming together at all levels of existence. Experiences of mental illness or mental wellness are not found to be pre-existent individual states.

Ideologies such as recovery philosophy and cognitive therapy are found to be means by which capitalist notions of self-reliance and competition can be interpreted as just

commonsense, so that inequality is something to which we must adapt. An expectation is noted, that emotions should be managed like industrial unrest or stock market panic, as unfortunate interruptions in the smooth running efficiency of economic markets. Having summarised patterns in the data, this chapter considers the reflexive quality of the analysis in a fifth section. The regulating role of mental healthcare is considered along with the slippery nature of our emotional state and associated narrative identities. The chapter finishes by considering how new metaphors might enable a better understanding of decision-making in this setting.

A critical stance is taken in the analytic process, in which the common social practice of ‘appealing to reason’ is questioned. In presenting a rational academic account, this thesis could be criticised as also appealing to reason. It is important therefore to emphasise the emotional aspects of the analysis work, to remain connected with the feelings participants express. We live in the same society as people who are excluded, homeless, mentally distressed, and stigmatised. Our emotional connection to others must be attended to and not simply cut off as an unwanted feeling or intrusion in the smooth rationality of our analytic thinking, or something which creates bias in our use of methodology or clouds the logic of our arguments.

What did this study find?

1. Making sense Whether participants are suffering from mental health problems or not, they feel they must account for their choices. They work to connect their emotional disposition with their calculation of self-interest, as they make decisions in the particular social contexts in which they find themselves. A woman for example, decides on impulse to separate from her husband, but then prepares a list of pros and

cons so that she can explain to others why this action would be in her interests, given her social circumstances. Similarly, participants who suffer from psychosis decide to live a homeless and vagrant lifestyle. They describe the emotional discomfort they feel when detained and treated against their wishes or when they are placed under pressure due to the proximity of intrusive others. Their choice to avoid others by wandering is then understandable. This accounting for choices is not always possible, however, and mental healthcare is found to be a source of meanings, with which people can categorise each other, proposing that the integrity of their being is disrupted by processes acting at emotional, psychological and social levels.

2. Under scrutiny When participants fail to connect their emotions with their self-interest in the context of their individual lives, they feel they are subject to the scrutiny of others. This feeling of being watched or exposed is again experienced by participants whether they are diagnosed as mentally ill or not. A man who suffers from psychosis no longer feels able to travel because his activities are now recorded on computer systems. Similarly, a woman who suffers from fluctuating moods feels that she is being watched and people are waiting to catch her out when she makes minor mistakes. It is found that an internally connected form of rationality is not easy to achieve. Participants depend on honest relationships with others, along with many practical resources and sometimes psychiatric treatments are necessary.

Senior workers sometimes feel paralysed or terrorised, because the decisions they make will be examined by others and criticised. Although they experience a desire to help people, it is difficult for them to express this within the constraints of time and limited resources in an institutional system. This is understandable as a form of

facticity which brings these workers into being in a time and place. Other participants also find their choices are limited and some feel that opportunities are denied to them due to distressing and intrusive experiences. Although we are all limited by our embodiment and the circumstances of our existence, these participants feel they are more exposed and more often picked out as deviating from an expected rationality. But all participants must make choices and their status as rational or irrational depends on many factors, most of which are beyond their immediate control. Yet this rationality is demanded of them in the economic structure of our modern industrial societies.

3. Attached meanings When participants are understood as acting rationally or irrationally, this is most often because, for some, the meanings that are promoted in mental healthcare have become attached to their person. The notion of ‘mental illnesses’ is cited, along with the idea that reasoning is hindered by ‘psychological distress’ or by ‘experiences of social isolation, trauma or abuse.’ Other influences are claimed when participants refer to a ‘lack of time or limited resources,’ ‘intrusion or pressure from others,’ the ‘constraints of bureaucracy’ and ‘institutional systems.’ Participants talk about these factors as overcoming individual autonomy. However, everyone faces choices and again, all participants would prefer to be understood as making their own choices, being as rational as they can, given the challenges they face.

When a participant’s ability to make autonomous decisions is in question, this leads to complex disputes. For example, a woman who cares for her daughter explains how her own emotional concern is an appropriate response, while workers appear to

dismiss her demands for help, because she is 'over emotional,' while for her, these workers appear 'emotionless and uncaring.' Meanwhile, a mental health nurse explains that he is expected to forge mutual decisions between people who have contradictory agendas. He is held to account if a rational plan is not enacted and he might be understood as 'uncaring.' When the emotional health and rationality of participants are placed in question in this manner, the knowledge systems of mental healthcare are granted a regulatory role.

4. Containing knowledge Because participants are subject to the scrutiny of others in their decision-making processes, it is difficult for them to make unwise choices. They are held under the discipline of an external rational analysis. Although it is not possible for anyone to be rational every hour of the day, participants are pulled towards this ideal by the knowledge systems of mental healthcare. Therapies and treatments are not experienced as helping participants make sense of their lives or enabling them to feel better. These interventions are experienced instead as regulating moods or controlling behaviours.

As participants place each other under scrutiny, they hold and contain each other in different ways. Workers sometimes feel a need to hold the people they try to help at an emotional level through regular contact in mutual decision-making processes, trying to relate to them as equals. At other times a worker might just pass information, as a means of holding someone separate, as independently accountable for their choices. The proximity of others and the imposition of routine are experienced by some participants as containing, while for others this feels abusive. But being left alone to hold the intrusive meanings which others impose can also be distressing. The

notions of being involved in decisions, or not, are experienced in many different ways.

This has implications for practice as follows:

1. Being themselves I might have argued that, if professional practitioners are to recognise and support human potential, they must take time to reflect and take more care in the formulation of understandings, so that simplistic or narrow interpretations are not imposed by one professional group or another. However I am mindful that the constraints of limited time and resources are often ignored when recommendations are made about professional practice. For example, participants in this study find the imposed rationalised systems of 'Managed Care' are reducing their resources, taking away their creativity and placing limits on their choices. These workers report that they face more needs and risks than they can manage and rational systems do not resolve this.

The senior workers who participated in this study speak about being 'real,' 'sincere' and 'honest.' This is their response when they do not have the time or resources to meet the commitments they must make. They are facing difficult realities which pull emotional responses from them. It is my impression that this response is not just about mediating processes of rational calculation or imposing knowledge frameworks. It is expressed directly in interaction with others. They could perhaps, be more frank in dealing with colleagues, managers and commissioners, so that it is not only the people who need help who are made to understand that needs cannot always be met and not all risks can be resolved. So, rather than recommending a more rational system to improve decision-making, I would ask that people talk more about their human

experience, that they should become themselves through the shared difficulties they encounter. They should make decisions with honesty, as humans, rather than hiding behind standardised procedures. These decisions will of course be challenging, emotive and contested. It might be useful therefore, if, rather than putting pressure on each other to make judgements, people work together with a tentative hypothesis.

2. Being constructive Many participants describe how they are unable to make their preferred choices due to intrusive events which impinge on their lives, or when they are taken up in routines and regulated practices in an institutional setting. I cannot argue, therefore, that they should always be understood as acting on their own volition and I find that they are routinely understood as making the same choices as others anyway. For example, when a worker makes recommendations, they can be dismissed as just making the same choice as anyone else would in their role. But then, if they fail to recommend that which another worker would, they can be understood as failing in their duty of care. Similarly, when patients express their personal views this might be dismissed as delusional. Perhaps I should recommend that we get rid of any form of professional knowledge, guidance or service protocol, demanding that people act on their own volition and acknowledge all experiences.

I must, however, conclude that constructing and following a bureaucratic system is a human response to the limits of time and resources. I suggest again that workers are more effective when they find creative ways to respond to this; when they express their individuality through a rebellious but constructive challenge to the institutional system. Workers must have the courage to stand up, or stand out. If we can be more tolerant in our understanding of individual differences, we might understand that there

are many ways that people contribute to family, community and our environment, other than through paid employment. Perhaps we can then find ways to value those of us who struggle to give shared meaning to our existence.

3. Shared humanity I found that the participants who come to the attention of mental health services are already embroiled in complex disputes in which the rationality of their actions is in question. Workers are professionally trained to give meaning to these actions by citing processes that act at those different levels of analysis; as social workers, psychologists and psychiatrists. In these conflicts we need to find creative means of enabling human choice or possibility. But participants are more often drawn along by the meanings generated in complex professional systems, where possible ways of being are constantly opening and closing for them. The question of whether a young woman is traumatised by rape or suffering from psychosis, for example, is not just about what happened in the past but about what kind of future will be imposed on her. It seems that her emotional experience became disconnected and was given meaning within the remote agendas of others.

Different ways of holding people or giving information mediate our self-understanding and emotional disposition. Some participants enjoy a comfortable sense of emotional containment, while others feel confined in an impoverished institutional system. When participants are 'informed' there is an expectation that duties will be taken up, while sometimes these responsibilities are resisted. I would like to work in a mental health service which does not reduce people to a problem to be solved by only understanding them within narrow perspectives. I would like responsibilities and associated decisions to be shared in a more equitable manner. I would like to celebrate

each person's unique response to their life, recognising the particular circumstances of their existence and sharing our common human qualities.

4. Tolerating discomfort I notice that the experience of mental illness is associated with a loss of control over behaviour, a loss of agency or sense of self. However, for participants in my study, mental distress is connected with insular and separate forms of decision-making, in which a person's identity becomes fixed. The knowledge systems of mental healthcare are resisted and misunderstandings or disagreements prevent the development of mutual understandings, through which people might grow or develop. I suggest that we should not dismiss emotions as symptoms, or promote a limited form of coping, as this does not enable people to engage with the truth of their existence or reach towards their possibilities.

While those who are labelled as mentally ill are fixed in these understandings, it is the workers who provide treatment and prevent risk who more often experience a loss of control, in which they have an ambiguous sense of self, hurrying about to meet the agendas of others. Participants often face a dilemma as to whether they should stand up to be recognised as an individual decider with a particular nature and intention, or to allow others to give their choices conflicting meanings. I suggest that as workers we should step forward to experience the conflicts we all feel in our encounters with existence, to acknowledge the distress of others and stay with the discomfort this engenders. We can recognise the limits that an embodied state engenders while also recognising a shared need to give life meaning in this unfolding situated existence.

An evaluation of the study

The study asks how the knowledge systems of mental healthcare influence enable or limit involvement in decision-making. Lived experiences of decision-making are explored, so as to examine questions of control and freedom. This study is an attempt to promote an integrated, more holistic or human form of understanding.

Human potential is not recognised when meanings are attached to behaviour so that vulnerability and incapacity are emphasised. The study tries to turn away from processes which define individuals so that they can be changed, made better or fixed. Attention is paid instead to the institutional and economic systems by which the possibility of human decision-making is both enabled and limited.

It is suggested in this thesis that decisions are often an outcome of complex interpersonal flows of emotion, forged in encounters in which we are making sense of ourselves and other people, giving meaning to behaviour. The study has opened up many ways in which people feel they are involved or not involved in decision-making processes. It has found conflicts where participants have different expectations around this. However, the study does not provide simple or clear definitions. It is not easy, therefore, to introduce new ideas or forms of understanding when giving an account of these complex and contradictory encounters.

Ricoeur (1992) suggests that understandings are clouded by metaphors which have outlived their usefulness, becoming part of the sediment of knowledge and practice. This thesis attempts therefore to generate new metaphors, so as to bring fresh understandings and ways of being. However, the structure of the thesis involves

placing participants together in five analysis chapters, where there are shared experiences. This might maintain understandings of people as falling into the categories of 'mentally ill' or 'mental health worker.' But it is noted that these are aspects of experience which participants bring to their encounter with the research process and these do not limit our understanding of the broader nature of their lives.

The study is limited in the sense that important questions are opened up, with little room to explore these in depth. For example, further research would be useful in considering the reasons why people choose to use alcohol or illicit substances to excess. Mental health problems have a complex relationship with these behaviours and a clearer understanding of this would be useful. Similarly, the analysis glosses over areas of decision-making which could be given more attention. A detailed analysis of the decision to detain under mental health law or to provide psychotherapy or prescribe a psychiatric medication would all be useful. More consideration could be given to decisions related to suicide. Is this action always the outcome of disease processes acting against the will of the individual or can it be an expression of freedom (Cohn, 1997), for example, and how should other people respond?

By including participants who have different experiences of the topic, complex problems are generated. The more tangible simple aspects of the phenomena become obscured as more and more information needs to be considered in drawing the analysis together. Even so, the sample is not representative and perhaps the analysis would be more complete if accounts of a personal experience of self-harm behaviour had been included, for example. However, there is adequate complexity so as to give the analysis richness, bringing a more meaningful form of understanding. Examining

the close detail of a small sample enables this specific but limited understanding, so findings cannot be generalised to other setting. Decision-making and mental illness might have different meanings in other contexts. However, by drawing on existential theory, some degree of understanding can be shared by everyone, as we must all make decisions and we are all limited by our biology.

In a phenomenological study it is not appropriate to suggest that one way of understanding is better than another, as no sense of a right way to be or a 'good life' is presupposed. Being mentally ill or mentally well must be examined on an equal footing. However it would be useful if new ways of understanding could be developed, so that people are able to recognise their limits. Failures would not then be automatically attributed to problems in individuals, such as a flaw in their psychology or physiology, or a form of social vulnerability. Also, it is not helpful to understand the social world as always toxic and inevitably causing trauma.

The study generates unexpected findings. It was not thought that people who experience severe and enduring mental health problems could be understood as more fixed and stable in their disposition than the workers who try to help them. It was not expected that a family carer would try to promote a biomedical understanding in opposition to a psychiatrist who sought social and psychological explanations. The manner in which people are not aware when their moods are disturbed was not expected, nor was it thought that interpersonal trust in relationships would be found to be central to managing this.

Mental illness is associated with stigma and shame. But we can all feel that we lack something when we are not as rational as would be expected. We are somehow inadequate and are therefore called to account because of this. No claim is made, therefore, for the existence of stable categories of person, who behave in a predictable manner as a consequence of suffering from a defined condition, so that a therapist might use that information to manipulate or cure them. The opportunity for change is found in the unpredictability of our being, in the unknown.

This study does not provide an account in which our emotions are calmed by a rational explanation. It is not intended that aspects of the unknown world should be made a little less frightening by giving them names and defining them. Mental health problems are not neatly explained away as something that only affects other people. It would be better for mental health services to leave aside notions of rational or irrational, to understand these behaviours instead, as an aspect of each person's intelligent and emotional response to their form of existence. The unknown is frightening but it is also the source of possibility and opportunity.

1. Making sense but being themselves

This section considers the manner in which rationality is understood to be hindered by aspects of a person's being which are separate from their thinking self; their bodily emotions, their lack of reasoning or a distressing social environment. Participants work to draw connections between these aspects of their being, so as to achieve a coherent sense of self. Power is enacted when they fail to achieve this cohesion and they are opened up so that the rationality of their choices can be examined and reviewed. Various rights and responsibilities are implied by this and, for example,

people who are ill have a right to be treated, but also a responsibility to maintain their wellness. Complex disputes occur in these circumstances and feelings of self-worth are supported or undermined, as moral judgements shift these expected configurations of accountability and entitlement.

The application of scientific knowledge in controlling the environment along with the rise of economics systems has an impact on the experience of being human in modern industrial capitalist societies (Latour, 1991). Meanings are imported from these technical practices so that human decision-making is now understood primarily as an individual rational calculation; a process through which a person moves towards their predetermined goals (Rose, 1996). These forms of understanding stand in contrast with the manner in which human reason, emotion and our place in the world were thought of in the past.

Rationality has become an assumed quality of our human condition, while different classifications of irrationality are identified through scientific enquiry (Foucault, 1967). Mental healthcare is then an agent of the state, acting to help us to attain an adequate degree of self-regulation (Rose, 1996). Questions arise however as to whether the promotion of this way of being is a moral, practical, liberating or oppressive imperative in our culture. The study asks how the knowledge systems of mental healthcare influence our choices. This question is set in context by considering the manner in which associated ideas and assumptions have developed over time.

When we are giving rational explanations for our choices, we are required to provide a neat account in which processes at biological, psychological and social levels are connected. For example, Olivia describes how she decided, on impulse, to separate from her husband (Chapter 4, pp. 102). Although she feels her choice is prompted by emotions, she also prepares a list of pros and cons to support this decision, in preparation for the experience of accounting for her action to other people. She can then attain the preferred social position of being someone who can make rational decisions, in the sense that she gains social and economic advantage. However, if our sense of self is not connected in this manner, one aspect of our being might be seen as incomplete or flawed; in need of correction. The manner in which this incompleteness is understood then imposes particular rights and responsibilities, thereby influencing decision-making processes.

A complex and ambiguous sense of being is expressed by Anna who experiences fluctuations in her mood (Chapter 5, pp. 144). Anna resists a medical understanding of her behaviour and she would prefer to be understood as ‘just having a rotten day like anyone else.’ She mentions her everyday disagreements with her partner, her family and mental health workers. In these encounters the manner in which her actions are interpreted as symptoms of illness or personal choices are in dispute. She describes an uncomfortable instability in her being in which these different understandings ebb and flow along with changing emotional states. She adopts an understanding of herself as ‘in the driving seat,’ when decisions are made, even though she can also see her choices through other understandings available to her. She

can see that her choices are somehow ‘the wrong decisions’ and at times she thinks of herself as having been unwell.

For many participants across the analysis chapters the experience of emotions is closely bound up with a commitment to various activities. They can then account for their feelings and choices as connected with a rational plan, linked with their social world. In caring for a relative or taking up positions of employment, participants talk about being emotionally engaged. Workers also speak of being more organised in their employed roles and at times they must set their feelings aside to manage difficult processes.

In Chapter 8, Ben, Chris and Laurie, who describe experiences of psychosis, choose not to enter into emotional commitments and talk instead about just drifting through life. Chris describes how he attends only to that which might make him feel good in the moment (Chapter 8, pp. 255). But when they are not engaging their emotions in interpersonal commitments their feelings can run free. Ben, for example, has a sense that in the eyes of other people his moods are too high or too low. Then, it can seem that there is no acceptable way for him to be and it is difficult for him to account for himself or explain how he feels (Chapter 8, pp. 276). Strong feelings of fear and paranoia can then come to the fore, which are exacerbated by the activities of the mental health workers who are employed to monitor and manage risks.

Rights and responsibilities

Naomi believes that her daughter is not able to make decisions due to the influence of a disease process, which she associates with extreme emotional distress (Chapter 4,

pp. 111). Her daughter, however, attributes her distress to an experience of rape and mental health workers entertain the possibility that abuse occurred in the family. These different interpretations open up expectations as to how rights and responsibilities must be distributed among the different agents who engage in decision-making processes. These duties and entitlements are cast differently when alternative means of making sense of events are drawn upon or imposed.

When participants refer to various explanations, in which different causes of mental distress are suggested, this is also linked to their emotion dispositions, to different feelings of self-worth or entitlement, of guilt or obligation. Someone who feels they are entitled to receive help might find they are understood to cause their own difficulties and they are held to account because of this; or someone who expects others to be responsible for their choices now finds that it is regarded as their fault that things are going wrong. However, these distressing feelings are thought of as problems which must be managed.

In the influential notion of ‘mind over mood’ (Padesky & Greenberger, 1995) it is suggested that we can engage with thoughts, changing our attitudes, so that emotions are better managed. Following this reasoning, in Chapter 7, participants who are employed as senior workers ‘pass information’ and then expect that people will make more rational choices. However, those who are employed as support workers, or are providing informal care to a family member, in Chapter 4, are critical of the manner in which a person’s feelings are dismissed as nothing more than symptoms of illness. Mira and Olivia claim that it is natural for people to feel their emotions and they question the prescription of psychiatric medication where it appears to them that

emotional experience is prevented. They also assume that if people could experience their emotions they would be able to make more sense of their lives, engaging with deeper meanings and forms of spirituality. While John, in that chapter, observes the complex flow of emotional responses in therapeutic relationships.

Foucault describes how divisions have developed between our emotions, our rationality and our place in the world (Foucault, 1967). He observes that, as European culture developed during the period of the Renaissance, madness began to be seen with poetic imagination. A person who had some form of intellectual or emotional impairment could be understood as a fool. But this role in society could also be taken up by someone who suffered no impairment, because an ability to stand outside of society was valued. The fool was thought to have access to divine understandings. It was believed that these understandings could give insights and bring knowledge which would be greater than that which could be attained through rational enquiry, due to the limited nature of human reasoning and the inadequate state of our communities.

During these periods human endeavour was experienced as innately limited and flawed, so that it was commonly thought that the guidance of a greater being was needed. The fool held status in society because the notion of folly could often be turned upon the individual rational decider, who was found to be unable to see the fullness of God's plan. Space could also be made for the divine aesthetic or prophet, a person who subverted their own reasoning through starvation or sleep deprivation, so as to gain a deeper or mystic form of understanding. Experiences which we would now view as self-induced psychosis could be seen as inspirational and motivating.

These ideas, however, are expressed by a participant in the study who describes how he is challenged about his use cannabis (Chapter 8, pp. 261). Chris says he uses this substance because it hinders his decision-making and he is perhaps opening himself up to less rational means of making his life meaningful.

However, Foucault observed how, through the rise of humanism, the rational decider has come to be constituted as the normal state of human existence, through the definition of the abnormal. Under such scrutiny this normal state of being becomes invisible, unquestioned, while the abnormal also becomes normal by being portrayed as a naturally occurring scientifically observable phenomena; a mental illness. This supposed ‘abnormal’ aspect of the natural world is understood as something we must contain and manage, in our exercise of ‘mind over mood.’

Implications

Workers are trained within narrow disciplines and they can become caught up in disagreements, making claims that rationality is undermined by processes acting at different levels of analysis. As described by participants in this study, workers are not just offering professional opinions and patients are not just reporting symptoms, they are all caught up in disputed emotional commitments. A person might feel wronged, hurt and entitled to receive help, but through the understandings that others impose, they suddenly experience themselves as damaged, sick and powerless. Someone else might think they are providing expert knowledge so that a person can be empowered to resolve their problems. But they remain responsible for solving those problems, which that other person generates in a repeated and reckless manner.

This study shows that these conflicts would not be resolved by imposing a more comprehensive or rational system, because participants who are employed in senior roles, in Chapter 7, are already struggling to apply these structures. Diana and Kevin describe how these systems can limit their choices and their creativity. It is when these participants are connected with the facticity of their existence, their human condition, that a 'real,' 'sincere' or 'honest' response is prompted. This response is engaged with the processes by which we are brought into being, through the manner in which we are understood. Workers are then 'showing a more human side of themselves' (Addis & Gamble, 2004: 453). They are caught between the restrictions of standardised procedures, limited time or resources and the overwhelming needs and risks they encounter. Also, the accounts of participants in Chapter 8 suggest that a human response is of far greater value than the cold indifference of institutionally regulated care or treatment.

Workers are struggling with imposed rational systems and perhaps they should be more 'real,' with managers and commissioners, explaining the reality they encounter, that a rational system can never meet all needs or resolve all risks. Rather than putting pressure on each other to make judgements, working together with a tentative hypothesis could enable a more supportive and involving approach in mental healthcare (Wharne & Splisted, 2011). In contrast, the notion of recovery is promoted, as if rationality were a natural state to which people should be returned, as if they could be put back together with the sticking plaster of a 'biopsychosocial model.' The material presented in this study suggests that rationality is only ever a potentiality; a state which ebbs and flows as the meanings of the past are reworked, influencing

decision-making and creating alternative futures. The manner in which these possible ways of being are supported in complex networks is examined in the next section.

2. Under scrutiny but being creative

In Chapter 8, Ben, Chris and Laurie describe how they lose their way in life, wandering and drifting away from friends or family. Working towards long-term goals is no longer possible and immediate gratification becomes their priority. Alternatively, participants in Chapters 6 and 7 become enmeshed in institutional routines and responsibilities so that they must suspend their personal wishes or desires, to enact that which is expected of anyone in their employed position. They align with others in taking up these activities, as behaviours and events are given meaning within different forms of understanding.

Networks of connections can be traced where they run through professional bodies, where conflicts are played out in academic research, legal disputes and the revision of Government policies. Other connections run through the family and friendship networks in which participants explain their choices and give meaning to the nature of their being. In this complex connectivity mental illness is not only thought of as a personal experience and economic markets are understood to depend on everyone's productivity and rationality. Emotionality has a contentious position in these understandings where connections enable changes across the personal and the collective aspects of our being, distorting and limiting our options.

Laurie describes how he avoids psychiatric treatment and regulation by wandering (Chapter 8, pp. 264). The complex networks that support rationality are then severed. When he is left homeless or isolated on a hospital ward, for example, rebuilding social connections which would enable him to take up employment or engage in intimate relations is not found to be an easy process. But in contrast, the notion of the pre-existent rational decider brings the expectation that the non-human world is an inert resource which can easily be drawn upon. This is not the experience of participants, when they are disconnected from the usual means by which people meet their needs or exercise choice. Mental health problems could be understood as caused by experiences of isolation or a response to abusive relationships, but our freedom to connect or disconnect in various ways suggests a more complex picture.

Laurie reports that he does not build connections within the cold impersonal rationality of an institutional system (Chapter 8, pp. 259). Imposed treatment or proximity to others does not resolve his experiences of distress, trauma or isolation. In that Chapter, Ben is also rejecting the interventions of mental healthcare. He seeks meaning instead in a more personal or spiritual manner, in responding to the events of his life as an expression of fate or God's will, for example. In these experiences, unexpected occurrences can reveal a plan or purpose to which participants feel they must attend. Life events are not then dismissed as random, but are used instead to give meaning and this helps a person to make choices which are significant for them. For example, the kindness of a stranger who provides sandwiches and coffee is a form of connection which influences Ben so that he decides to settle in a town he has

randomly visited (Chapter 8, pp. 253). This is an investment in personal meaning rather than a rational calculation of self-interest.

Life becomes meaningful at both emotional and cognitive levels as we respond to experience. Within professional networks however, emotions are understood as biological processes. They are only thought of as active when the effects of mental illness are observed. Attention is drawn away from our ordinary embodied state, in which biology is also active in enabling our everyday rationality. While some participants have found meaning in the apparent random events of their lives, other participants find meaning in the random behaviours that are generated when biological systems fail. These workers then attach agency to an active disease process which is seen as separate from a pre-existent rational decider. Ben is detained under mental health law because he is understood in this way and he experiences this as a burden he carries. However, we all encounter biological limits and we must still make our lives meaningful.

There is a sense of shame if people do not make good choices and it is a common social practice that the grounds on which they should have made decisions will be revisited. Participants mention feelings of being watched, expecting that their choices will be placed under scrutiny. Ben describes how he no longer feels able to travel when his activities are recorded on computer systems (Chapter 8, pp. 253) and Anna feels that she is being watched, people are waiting to catch her out (Chapter 5, pp. 145). Experiencing this intrusive gaze is creating a form of self-regulation in which most people internalise rational systematic forms of self-analysis and self-regulation.

We might sometimes choose not to meet our basic needs, testing our endurance against hardship. But most often we struggle anyway to maintain a sense of personal coherence in an unpredictable world. We depend on the action of alarm clocks, diaries, pre-prepared foods, organised storage space, personal space for reflection, door keys, bags, pockets, mobile phones, reliable means of transportation, trustworthy people, a routine of finding oneself in familiar places at regular times; but also the freedom to break routine and take a fresh look from a different perspective. A fault in any of these connections can in a moment rob us of our sense of stability, taking away our control in an alarming manner and frustrating our efforts to attain that calm reasoned self we would prefer to be. Our actions are not however determined by these difficulties, it is more that our being is shaped by our response to this facticity of our particular existence.

Spreading rationalism

Participants describe intrusive experiences and these are often associated with fluctuating emotions, where the decisions that are made in one moment are later found not to be what the person wanted. The person struggles with the situated nature of their choices where it is expected that they should be able to enact a pre-established rational plan. There is then an apparent disconnection between rational intent and changing emotions, which sometimes reduces that ability to plan so that choices are made about immediate gratification, or spontaneous wandering. But for other participants neither self-gratification nor spontaneity is possible in challenging work routines, where professional policies and legal guidelines must be followed. These complex forms of governance also extend into a network of connections. Diverse negotiations are enacted and participants must align their choices with all other

professional workers who act in a similar role. Kevin, for example, says he is applying the same diagnostic criteria as others in his role, while following professional guidance, research outcomes and legal rulings (Chapter 7, pp. 231).

In other times and places, choices might be spoken of in terms of desire, fate, supernatural forces, or allegiance to family and community. But with the rise of individualist understandings, along with the emphasis which is placed on reasoning, much of this variety in our ways of being is lost to us. Individualist philosophies are apparent in writings such as that of Adam Smith in *The Wealth of Nations* (Smith, 1776/1993) for example. Our passions, our encounters with happenstance, with the will of God, or our shared community bonds, are replaced by the ‘invisible hand’ of the market place. The market system adds up the decisions of multiple individuals, creating a financial dynamic which then imposes its structure, while the stability of this system somehow remains the responsibility of each individual (Ritzer, 2008).

Max Weber observed that we are driven in industrial societies by processes of rationalisation (Ritzer, 2008). An individualist means of configuring our communities is promoted to such a degree that market economies and self-serving interests must be extended into all human activities, including public services such as mental healthcare. Competition is promoted in a free marketplace, where self-assertion is the foundation on which organisations are built. Then in this economically driven construction of the individual decider, mental health problems are not just an aspect of personal experience. They have become an unnecessary drain on state finances, as mental health policy is influenced by economists such as Richard Layard (Layard, et al., 2007). In order to ensure that the economy grows, we must all be made more

rational. Following the reasoning of Samuel Smiles (Smiles, 1993/1879), if people are not rational and self-seeking in their choices, they will be burden to their friends, their family and the state. It is assumed that it is only by harnessing individual people to the machine of economic productivity, that their 'base instincts' can be managed.

The efficiency of democracy and of multiple international markets is understood to depend on individual calculated self interest, and emotions are cast as a problematic form of interference. Feelings of panic can be thought of as dark forces threatening the stability of economic markets when stocks lose their value. Other emotions, such as greed and intolerance, can be thought of as undermining democracy in corrupt Governments. If workers take industrial action they can be viewed as stubborn or lazy in a manner that would hinder productivity, and family loyalty can be interpreted as no more than a destructive form of nepotism. These understandings are imposed by economically driven changes which do not leave enough person shaped spaces, or the nature of the person must be distorted and made rational so as to make them fit.

Implications

Participants describe how their intentions cannot always be enacted when intrusive events impinge on their lives, or when they are taken up in routines and regulated practices in an institutional setting. But personally meaningful choices are not valued anyway in modern economically driven societies. Mental healthcare is assimilated into a rational system in which the regulation of apparently random behaviour is promised. By giving random events the meaning of a disease process which can be managed through medication, mental healthcare takes up a valued role in maintaining economic productivity. However, people who struggle to give shared meaning to their

lives can contribute to family, community and the environment, other than through paid employment (Wharne, et al., 2011).

It is difficult to give personal meaning to choices in an economically driven rational system and, at the same time, the manner in which people are routinely understood often means that their choices are viewed as aligned with those of others anyway. If a worker makes a recommendation this might be dismissed as something anyone else in their role would suggest. Or if they fail to recommend that which most workers would, then they have let their personal feelings cloud their professional judgement. It seems therefore that we should just get rid of any form of professional guidance or service protocol and demand that workers respond as a person who acts on their own volition, responding directly to the needs and risks they encounter.

However it is unlikely that guidance and policy will be set aside, so we will continue to know people as individuals, only when they are viewed as deviating from the norm in some way, as in the notion of an uncaring nurse or psychotic patient. These ways of knowing are examined in the next section. Being known as different is experienced as a burden someone must carry and problems are located within them. But, we are all limited by our biology and the failure to care for people in our society is surely a burden we all carry.

3. Attached meanings but shared humanity

Different forms of freedom are available to participants when they face the dilemma as to whether to take up opportunities or somehow avoid them. Participants can be understood as encountering choices when social positions are available to them.

Although there is a biological foundation to our embodied being, various positions such as mentally ill or rational decider are also narrative roles which people step into or otherwise find themselves occupying.

Freedom creates anxiety and the idea of containment is mentioned by participants who struggle to hold themselves and others in a consistent sense of being. Workers try to see people in regular routines or they work to ensure that they have information on which to ground their choices. The ability to experience freedom, to take control, or to give lives meaning, are all mediated by these interpersonal emotional processes. Holding people without giving information can feel oppressive, while just giving information leaves them feeling abandoned and isolated.

Pulled into rationality

The decision to take up a position in society as a rational decider is not a simple matter. Participants are not isolated in their decision-making and processes of interpersonal emotional connection mediate their choices. Participants describe how they need to feel able to trust others, to manage ideological understandings, to experience meaningful life opportunities, to gain practical resources and personal space. These experiences suggest that sometimes the position of a rational and responsible decider is taken up; sometimes it is thrust upon a person. It might also at times be just somewhere that a person finds themselves, or even a position that they carefully avoid. Taking up that position in society does involve experiences of loss, but also, there are losses if this position is not attained.

Participants who are employed as workers describe their efforts to pull people into states of rationality, where for example, Greta explores the reasons why someone chose not to take prescribed medication (Chapter 6, pp. 198). If this action were interpreted as a rational decision, rather than a symptom of illness, then Greta can hold that person to account and thereby tie her more closely into interpersonal commitments. The other side of this story is told by Anna who also stopped taking psychiatric medication (Chapter 5, pp. 160). In exploring her reasons for this decision, Anna experiences herself as experimenting, as employing a strategy and learning from the consequences in a rational and scientific manner. But in contrast to this, Frank appeared to avoid this position of self-regulation, by understanding the recovery of his mental health as ‘just a fortunate thing that happened,’ rather than a process over which he might have some control (Chapter 5, pp. 140). In an existential understanding a person might be inauthentic when taking medication to avoid experiencing the emotions which their lives cause them to feel (Stevenson & Knudsen, 2008). But they are also inauthentic when denying their ability to take control over emotional processes. Both actions might be seen as a refusal to take up to the freedom they might exercise.

The question of whether someone acts with freedom or not is important within the rational bureaucracy of mental healthcare, but it is difficult to establish. Emma finds that she is expected to employ her professional judgement by deciding whether someone is choosing not to maintain standards of hygiene, in an exercise of their freedom, or whether they are unable to maintain cleanliness due to the effects of a disease process (Chapter 6, pp. 196). This question of illness or a personal choice is founded in problematic and confused dichotomies of biology or choice and there are other

participants who struggle with this. Chris, for example, describes how he prefers to opt out of society and he is, perhaps, reading an understanding of personal choice back into the distressing events of his lives (Chapter 8, pp. 281). But he also accounts for his action of making poor choices as a consequence of being unwell at the time.

Containment

The notion of containment is mentioned by Ian and Greta in Chapter 6, who express concerns, that the people they are helping are not able to make safe decisions on their own. Containment is associated with routine contact and joint decision-making. Other sides to this interaction are described by Anna, Frank and Peter in Chapter 5, who struggle with fluctuating moods and by Ben, Chris and Laurie, who experience psychosis. For those who cannot trust their own feelings, the experience of sharing decision-making processes in trusting relationships is most often experienced as containing. While the experience of psychosis can mean that a sense of trust is rarely achieved, so that being held is experienced as oppressive and distressing. An essential human need is expressed in the desire to have space of one's own. John Bowlby (Bowlby 1988) observes that it is difficult for parents to find the right balance between dependence and independence when enabling children to mature. It is claimed that unresolved experiences of distress can influence styles of relating in adulthood. However, perhaps we all face the dilemma of whether we should move closer to others or keep our distance. Perhaps this can never be fully resolved and continues to be played out in all relationships.

Greta describes how she is committed to seeing the people she helps in a regular manner, so that the reliability of her contact can be experienced as containing

(Chapter 6, pp. 187). In contrast, Diana describes how she is just informing people (Chapter 7, pp. 228). She is holding them within boundaries so that what they choose to do is their concern and rights, desires and responsibilities then exist within one person or another. This feels like a severance of connections and the notion of holding information extends a containment metaphor so that people can be seen as a kind of information processing device. It can be assumed that everyone will act in a rational manner, if they are given the necessary information with which to make their decisions.

Diana describes her role in assessing people under mental health law (Chapter 7, pp. 223). In her view, she is helping people to make rational decisions in which their freedom is maintained; their freedom that is, not to be detained in psychiatric hospital against their wishes. In her experience she is just giving information while she is aware that the people she assesses experience this as a threat. This experience of being threatened is then explored when Ben finds that in receiving this kind of information, he feels like people are intruding into his space, ‘getting under his skin’ (Chapter 8, pp. 270). Like Chris and Laurie in that chapter, he responds by internalising interpersonal boundaries and existing as an individual. But these participants then avoid contact with other people, living homeless for example, and they never fully evade the feeling of being watched or controlled.

The pre-existent rational self

Psychological researchers turn increasingly to questions of how rationality might be enhanced (Kahneman, 2011). The Government in England and Wales invests in Cognitive Therapy, an approach which explicitly promotes the rationalisation of

thinking, along with an associated management of ‘unwanted feelings’ (Padesky & Greenberger, 1995). This kind of state sponsored psychological therapy can be viewed as a means of making people adapt to untenable life situations; to many hours of underpaid and unrewarding employment in an economically driven rationality (Cromby, et al., 2007). Oppressed workers might even be required to display emotions appropriate to their work role, as opposed to their subjective disposition in a kind of ‘emotional labour’ (Hochschild, 1983).

When empirical psychological methodologies are employed it is often assumed that rationality is the natural form of human decision-making. A failure to succeed in society due to an inability to make good choices is then viewed as an outcome of a pathological process. A form of modelling is promoted when psychological and psychiatric knowledge is taken up in our self-regulation, within which the interaction between psychological and social is removed. Divisions are opened up between the mind and biological process, or social context, in which ‘chicken or egg’ problems develop; does a person make bad decisions because they are a poor decider, or are they a poor decider because they make bad decisions? A similar separation is often created by ‘nature/nurture’ debates, which place an unhelpful divide between our biology and our experience.

The risky self

The separations that are inherent in the way we think about ourselves create the idea of a ‘risky self’ (Ogden, 1995). This is a troubling notion that arose across the twentieth century causing much moral panic. While it was previously thought that the integrity of the self might be damaged by an external contagion, deviant identities

were constructed such as the ‘alcoholic,’ the ‘schizophrenic’ and the ‘psychopath.’ It is then the person themselves who is troubling due to their inherent inability to make rational choices.

Statistical analysis is used to strengthen the idea that we can all be categorised. The idiosyncratic and contingent are ironed out as outliers are removed and then the observed psychological subject represents a category of persons; they are a psychological type or a diagnosis, having no individual voice of their own (Danziger, 1990). Such homogenisation can rob us of our uniqueness and cast us more concretely as ‘this or that kind of person.’ Although people might resist, while they are viewed through psychiatric or psychometric assessment, the rationality of their decisions is understood to be distorted or biased due to the influence of a psychiatric condition or personality trait.

In contrast to the understandings of psychiatry and psychology, the accounts of participants in this study tells us that decision-making is not grounded on a simple form of forward acting determinism. They are self-aware and consider future possibilities making choices that are influenced not only by what happened but by what might happen. But when causal models are imported from the natural sciences time is regarded as moving forwards and people as having stable dispositions which are treated as fixed variables. In these simplistic interpretations it is presumed that choices come about due to the nature of the person and the consequences of their decisions are played out in the social world they inhabit. However, the interaction between the psychological and the social can be understood as operating the other way. The deviant nature of the psychological subject is seen to be constructed within

a 'moral order.' working backwards from decisions which are currently being attributed to that person (Wetherell, 2008).

The nature of our being is an outcome of our social contacts with others, as our lives are mediated by the shared understandings of the moment; "*where memory is 'localised' in the material contours of the world*" (Middleton & Brown, 2005). In our mundane conversations we cut out boundaries, moments, interpretations and specific meanings from a complex flow. It is then only a shared understanding of what takes place that is made accessible to us; because by living in a habitual routine, encountering 'like-minded people,' we hold in our memory only the paths of common forms of thinking or feeling and, usually, we forget the vast majority of our daily individual experience (Middleton & Brown, 2005). In this forgetfulness, it is only when we suddenly find that our understandings clash with those of the people around us that our assumptions come to light. It is then in the experience of these conflicts that we might experience ourselves as potentially a different kind of person, suddenly defined by understandings which seem quite alien to us.

Implications

When accounts are given by different participants and different sides of complex encounters are considered, it is easier to see the manner in which people might choose to take up narrative identities. Alternatively, they can find themselves pulled into these positions or they could try to resist this kind of social positioning. Complex encounters in which possibilities are opening and closing moment by moment are experienced by participants where meanings are enabled or excluded. A need for containment is then experienced in these volatile encounters.

Some workers who participate in the study speak about holding a person emotionally, through regular contacts, a sharing of experiences and the forging of mutual decisions. Other workers describe their actions as ‘just informing people.’ This action of just giving information emphasises separation and responsibility, in an attempt to hold the other person to account for the choices they make. Questions can be asked about the effectiveness of just informing people, as Diana who adopted this approach observes that someone she informs continues to be detained under mental health law anyway (Chapter 7, pp. 223). Although she also describes how another person she informs takes action to maintain her health because she feels threatened.

When mental health workers try to pull the people who use their services into rational decision-making processes they are not always successful. The avoidance of this regulation might be seen as a fundamental choice, a choice not to fit in with society, but it is not a rational decision. When participants have endured isolated and insular forms of existence, this choice is not a weighing up of pros and cons and they are not mindful of the consequences of their actions. It is not appropriate to dismiss the complex emotional processes and intrusive social influences which have a significant impact, so as to only focus on matters of rational decision-making. The next section explores these complex emotional processes. Meanwhile, if workers attend only to matters of mental capacity, only measuring a person’s ability to hold or process abstract information, they will not be engaging with that person or understanding their experiences.

4. Containing knowledge but tolerating discomfort

It might be thought that the experience of mental illness is more likely to be associated with a loss of control over behaviour, a loss of agency or sense of self. For participants in the study, however, the experience of mental illness is often connected with an insular and separate form of decision-making, in which the person's identity is fixed and consistent. Although in achieving this consistent sense of self they often find themselves in conflict with others.

In taking up employment in mental healthcare participants are required to set aside their own emotions and intentions, so as to attend to the disposition of others, to follow established practices. It is this experience which more often imposes an ambiguous understanding of the person, or creates a split between their own preference and that which is required of them in their work role. This experience is driven by the voices of other people, such as that of senior colleagues and academic researchers, imposing a loss of control in which the person is often carried along by external processes and changes that are force upon them. However, exercising control is something all participants struggle to achieve, as they are drawn along in the cycles of their lives, in which rationality can only ever be a temporary state of being. This rationality depends on many factors but time is particularly influential.

Being in time

Participants who are employed as workers describe their efforts to stretch their resources and to make enough time to meet many conflicting agendas. If they fail to achieve this, the complexity of their work setting tends to be ignored and they are held to account for the one error that got beyond them. Ian, for example, is concerned that

his decisions are seen with hindsight as neglectful (Chapter 6, pp. 189). But there is, of course, no point in time at which he chose to make a mistake and if his judgement had not been placed in question, his disposition would not be retrospectively reconstructed. It can be concluded therefore that time is not linear in these calculations.

The situated nature of being in time creates cycles in the ebb and flow of emotions and states of rationality. Anna, Frank and Peter in Chapter 5, for example, explain that there are times when they sink into depression or become driven by an elated mood. They then made choices which they would not if their mood were more stable. Sometime later, through the interventions of others and the use of psychiatric medication, they are brought to a state which they experience as more rational. In these experiences they are brought into existence as rational or irrational in the current moment of their deciding, where there is no preformed self and no preset trajectory to their lives (Sartre, 1967). The past is never certain but always open to being reworked as choices are revisited and accounted for in different ways.

If our decisions were an outcome of a pre-existent self that we had not brought into being then we would not be responsible for them, because we did not choose to be that pre-existent self (Strawson, 1994). The freedom we have in our decision-making is always opening us up to the experience of being one kind of person or another, while at the same time there is an urge to resist any narrow interpretation of our narrative identity. Our self is always subject to the scrutiny of others who seek to hold us to account and this is uncomfortable. For example, Anna believes that she is 'in the driving seat' when she makes decisions, but also finds that she has made the wrong

decisions and she changes to accept the views of others; that she was ill at the time (Chapter 5, pp. 149). However she then resists this narrow interpretation. But she also explains that she now manages her difficulties by only making important decisions in the afternoons, when her emotions feel more stable.

We all lose the rationality of our being at the end of each day when we need to sleep. In our dreams we might believe that our actions are rational but on waking we become aware that they are not. Chris and Laurie in Chapter 8 describe longer periods during which they experience a loss of rationality and with hindsight they see this as being ill. However, Emma, Greta and Ian in Chapter 6, who are employed to meet conflicting agendas in mental healthcare settings, experience their actions as rational one moment and irrational the next as different understandings are expressed. This rhetorical positioning is also experienced where the decisions people make, are attributed to the action of an illness, to psychological problems, to social pressure, to personal intent or happenchance. People cannot control the manner in which their actions are interpreted and conflicting meanings compete in the flow of group decision-making. This can create a dream like sense of unreality, with transient and opposing understandings of our self as; ‘caring,’ ‘neglectful,’ ‘trustworthy,’ ‘burnt out,’ ‘rational’ or ‘irrational.’

A driven self

Fyodor Dostoevsky wrote about his concern that rationality and technology might impinge on individual freewill. In ‘Notes from Underground’ (Dostoevsky, 1864/1956), his anonymous narrator describes how he works as a bureaucrat, taking every opportunity to impose petty rules so as to cause people trouble. In every

encounter he tries to be as awkward as possible, making others follow his will for no particular gain. But if he made rational decisions, as any reasonable person in his position should, how would he know that they were his decisions? In choosing that which would be most inconvenient for others, he can take their annoyance as confirmation that he is not subject to their will. While the narrator is repelled and ashamed of his own self, he is driven to express it, in all its contrary perversity.

Dostoevsky claimed that if science were to discover a formula by which human behaviour could be understood or predicted, then people would lose their desire. They would be choosing by rule and would *“at once be transformed from a human into an organ-stop or something of the sort; for what is a man without desires, without freewill and without choice, if not a stop in an organ?”* (Dostoevsky, 1864/1956: 72).

Decisions in Dostoevsky’s interpretation are neither abstract nor general; they cannot be reduced to a rational formulaic procedure which everyone follows; they are mediated by emotional will, expressed in a confusing response to conflict with others.

Emotional expression, in the intensity of experiencing life, is identified in existential theory as uncomfortable and often distressing. However it is viewed as a better existence than the denial of our will which would be required in existing as no more than a cog in a machine. Fredrich Nietzsche also expressed these concerns about the rationalisation of society. Work, he suggests, involves a relentless industry from early till late, which takes energy away from *“...reflection, brooding, dreaming, worry, love, and hatred...”* (Nietzsche, 1908/1956: 104). Work is distracting us, setting small goals and permitting only easy satisfaction and security. Behind this harnessing of energy Nietzsche sees a fear of the individual, a fear of their capacity for choice.

The intensity of experience describe by Dostoevsky's narrator is also described by participants in the study, where other people, the constraints of time or a lack of resources pull them into difficult decisions which expose them to critical interpretations. However, this 'intensity of experience' is often understood as just a symptom of mental illness, an 'unwanted feeling' or 'emotional fatigue' which is assessed, monitored and managed so as to ensure that decisions are more rational. Soren Kierkegaard (1859/1956) claims that neither rationality nor institutional regulation enable us to escape the immediate moment in which there is a need to choose within an ambiguous and uncomfortable encounter with the world. In each moment that we live we are required to make choices and these will most often be thoughtless, habitual, reactive, intersubjective and most definitely under the influence of our emotions. This imperative usually acts to shape our psychological being in the particular circumstance of our existence and our ability to enact a masterful pre-planned form of control over an unpredictable world is severely limited. Most often there are just too many variables for rational calculation.

An empty self

Sartre (1967) emphasised the emptiness of our existence, where there are no essential qualities to human nature and given identical circumstances, we are free to make many different decisions. In this sense we are 'condemned to be free;' no other person can control us. This interpretation presents problems however because it brings us back to the idea of a lone decider who might achieve a greater degree of rationality. In contrast, Simone de Beauvoir wrote about rationality as typically middle class and male; as creating a kind of 'other' (Beauvoir, 1997). This 'other' appears mysterious, not being open to rational understanding; a position thought to be occupied (at that

time) most often by women, the uneducated working classes, people from ethnic minorities and the mentally ill.

People who experience the world within the position of the 'other' might face the barriers of poverty, exclusion, imprisonment and rape; experiences which do not engender freedom or choice. The alignment of rational with 'white maleness' is picked up by Gunaratnam & Lewis (2001) who contend that the emotion / rationality duality is a gendered-racialised separation and that this needs to be understood in all its complexity and nuanced meaning. Participants in the study may, to a degree, give actions meaning based on gendered or racialised narrative identities. However, it is in those processes of containment, of being held, helping others or meeting institutional agendas that their emotions are more clearly experienced.

For Sartre (Sartre, 1967), emotions are associated with the person's attitude to the specific life situation in which they find themselves. We experience ourselves in these moments when we feel our will is tested against fortune or in competition with others, in taking risks, in religious experience, gaining notoriety or fame, or in the extremes of our natural environment where we stretch our ability to survive to the limits. Choosing to engage in these activities might not be rational but they are the means by which we encounter ourselves. Participants who are employed as workers can be understood as testing themselves against the hardships of limited time and resources. They take the risk that their actions will be given negative interpretations. In contrast, participants who struggle with psychosis choose to face the hardships of living homeless, rather than fitting in with the expectations of others.

The gambler is most alive in the moment of the bet and to live a life within financial constraints would feel empty (Dostoevsky, 1867/1997). The risk taker, along with the extreme sports fanatic, or the hardened traveller, are all perhaps filling the emptiness of existence with these emotionally heightened experiences. Similarly, taking substances which alter mood (prescribed or illicit), might enable a person to experience more of their favoured emotional state, but this is commonly viewed as an avoidance of the realities of life. When a person is 'under the influence,' questions remain over the role of personal agency, which is perceived as an essential element in one's response to a life context. Chris describes how he smokes cannabis to impair his decision-making (Chapter 8, pp. 261). Perhaps he is filling the emptiness of his life with random meanings which might have more significance for him than a rational mundane existence. Also, Kevin is giving his life meaning by taking up employment in which he must make decisions which feel more weighty and important (Chapter 7, pp. 224).

Moods and emotions are responses to experience and Dostoevsky's narrator felt driven to hide away, avoiding other people. He describes his discomfort when picked out and asked to account for himself. He is distressed when subject to the scrutiny of others. Standing out and making one's own decisions, alone and separate from the crowd, can be a frightening prospect. So another response to this experience, as discussed by Heidegger, is to shelter under the cover of being the same as everyone else (Heidegger, 1962). That troublesome self, with which the narrator struggled, can be denied while we run with the crowd, doing what the person next to us does, fitting in and being reasonable, as Kevin also describes, when accounting for the weighty decisions he makes.

Mental health workers might adhere strictly to the procedures of their employed role whether this is actually helpful or not (Addis & Gamble, 2004). Similarly, accepting a psychiatric diagnosis is a means of becoming a ‘type of person,’ rather than an individual. But Sartre argued that these are unsatisfactory solutions, as we lose our moral position and our accountability (Sartre, 2001). In claiming that ‘everyone else does it too.’ or ‘it’s a symptom of my illness,’ we might for the moment avoid the intrusive glare of others. But sooner or later, we are all caught in the spotlight, centre-stage in a decision making drama, cast as rational or irrational.

The role of emotion in mediating our decision-making experiences and in constructing our identity is open to different interpretations, in which the interpersonal flow of emotion is emphasised or the individual experience of embodiment is brought to the fore (Blackman & Cromby, 2007). However emotions are central to our experience of choice and in the context of decision-making, the existence of freewill is demonstrated when people speak of; “...*the non-detached attitudes and reactions of people directly involved in transactions with each other: of such things as gratitude, resentment, forgiveness, love, and hurt feelings.*” (Strawson, 1960/1993: 48). This suggests that is in our emotional responses to others that we recognise their humanity their capacity to choose and we also gain our own sense of being in these emotive social encounters.

When decisions are understood as being made within emotionally charged relationships we are reminded that we experience emotions because things matter to us. People annoy or inspire us only because they are free to choose their actions. If they were not responsible for their choices then we could not feel indebted, admired,

let down, resentful, obligated, neglected, or committed. Encounters with others happen to us, molding our bodies in preparation for action. Emotions will turn our body towards or away from others in desire or empathy; in fear, disgust, or indifference (Ahmed, 2006, 2004). Emotions 'orientate' our bodies as our dispositions are formed in readiness for relating or not relating, in apathy or excitement, moving between placidity and tension (Frijda, 1986).

Implications

Participants express complex emotions. It is not likely that these could be reliably measured or categorised as a kind of private mental chemistry acting within an individual. We do not have 'primary emotions' which are mixed by our experiences into a particular hue, diluted or balanced in combination; instead, when we encounter others we have 'mixed emotions;' we feel love and hate at the same time; we are 'exited by shame, thrilled by danger and comforted by melancholy' (Pujol & Montenegro, 1999). It is these complex experiences which give our lives meaning and provide the motivation to engage with our existence.

Mental health workers are not likely to help people if they impose understandings in which a response to existence as an emotional, situated and self-aware being is denied. People are not stable pre-existing or separate individuals. They come into being through their emotional connection with others in place and time. The interventions of mental health workers should not be reduced to assessments of capacity and symptoms so as to diagnose, as these interactions are as much creating phenomena as observing them. They should acknowledge the distress of others and stay with their discomfort. They can then recognise the limits that an embodied state

engenders while also recognising a shared need to give life meaning in an unfolding situated existence (Aho, 2008).

Existence can bring feelings of extreme anger, fear and repulsion and workers struggle to express their selves, rather than becoming the objects of these emotional responses. In the immediacy and complexity of these experiences, Heidegger observed a fear that life will cease to make sense, a constant chaos in the background which hints at madness (Carr, 1986). So if we fail to appear as rational as we think we should, there is a feeling of shame and we can lose our sense of self, our sense of self-worth. We experience a pre-reflective anxiety and our lack of control causes feeling of vulnerability (Nussbaun, 2001). People need to remain connected with these essential experiences if they are to inhabit their work roles or overcome their life difficulties.

Reflexivity and new metaphors

This section considers the manner in which reflexivity is employed in the study. Linda Finlay recommends that researchers work with participants in a form of mutual collaboration, recognising them as reflexive beings, as co-researchers (Finlay, 2003). This is not a loss of the clear insightful individual perspective, but a means of moving beyond preconceived ideas, to allow multiple voices. She asks for a social critique in which there is sensitivity, or orientation to narrative identities, which asks how; are these categories maintained in dominant narratives; how are they used in the researched topic and the research process? This is recognising multiple, shifting positions of researcher and participant, where outcomes are seen in terms of access to power.

In a reflexive analysis an ironic deconstruction is often used, as in a celebration of paradox, often involving the use of creative and varied writing formats so as to give conflicting accounts, poly-voices, fact and fiction (Finlay, 2003). These techniques were used in the study to destabilise the professional understandings employed in mental healthcare. However care was taken to ensure that this is not too clever or pretentious as deconstruction creates a paradox around how the researcher's own project should be criticised, or supported as an authoritative account. The following two fictions are given as examples of this work in which the technique of imaginative variation (Van Manen, 1990) is also employed.

Making us rational

The study observes that in accounting for behaviour, participants refer to processes acting at social, psychological or biological levels. Pilgrim & Dowrick (2006) also observe that theoretical accounts of mood disorders tend to express contrasting and opposing forms of determinism. They note that these are related to common assumptions about internal and external influences on mental processes, such as an imbalance in brain chemicals, or negative habitual thinking, or social exclusion and isolation. In their efforts to consider the role of freewill they take a social-existential position, which; *"Does not contend that we are not determined beings, only that we are also determining being."* (Pilgrim & Dowrick, 2006: 10).

In my reflexive process, the possibility that we are 'determining beings' is found to be treated by mental healthcare as just another problem to be resolved in the maintenance of a rational society. This rationality is no longer achieved by removing and isolating individuals who do not make responsible choices. The state sponsored interventions

of mental healthcare must improve everyone's decision making capacity, by promoting 'mental wellbeing.' While I am the author of this study, I am also employed to achieve outcomes as a manager and a practitioner in mental healthcare. It is expected that I should ensure that people who are treated for mental health problems continue to take that treatment. However, to achieve this I must somehow manage their freedom, including their ability to choose not to take treatment. How can I offer people choices, enabling and empowering, when they might be detained under mental health law and treated anyway? It is not an easy process to step back from my own assumptions and I include the following fiction as an example of the processes by which I unpicked some of my understandings;

Government estimates suggest that three out of four of the population are currently suffering from rationality. These unfortunate people have no excuse when they make mistakes, as they are completely responsible for their actions. There is good news however, because more and more of these people are being rescued from their distressing condition by helpful workers who are employing psychological and psychiatric knowledge. Mistakes are thereby safely accounted for, not as an outcome of personal choice, but as the effects of determining processes acting upon us. Our understanding of these processes will one day enable us to remove all risks, making the world entirely safe. When that day comes, we will all understand what causes our behaviour and we will be able to adjust or compensate so as to be happier, healthier and more efficient members of society. Troubling options and choices will then be safely closed off. Embarrassing differences will be removed and we will all make the same decisions. None of us will make mistakes, as we will no longer be obliged to make any effort to achieve or to reach beyond our ability.

Perhaps we can understand psychiatric medication and psychotherapy as blunting the sharp edges of our awareness, so that being separate as an individual is more tolerable. This is of value to us if social encounters are made smoother, as if psychiatry and psychology are oiling the mechanisms of our society, making us all a little rounder and more polished in our definition. But when people fear they are losing their individuality they respond by being awkward, impulsive and contrary. We reject our self one moment then cling to it the next. Somehow we are never the self we would prefer to be and a biomedical model enables a split into healthy and unhealthy selves. We can then have unwanted emotions which we seek to have removed through the use of medication or psychotherapy. We can gain reassurance from friendly practitioners, who persuade us that our fears are ungrounded. We develop our rationality, trying to dismiss the nagging anxiety that cuts so deeply at our core.

State sponsored therapy, can be understood as a means of controlling populations and, along with the loss of individual freedom, there is also a folding in of instrumental rationality. We all become nothing more than a decision-making point in a rational social machine (Rose, 1996). The study questions the idea that mental illness is something that only happens to some people, but this is not to suggest that everyone should be subject to a kind of medical surveillance (Armstrong, 1995).

Flows of emotion

Academic debate considers the question as to whether mental illnesses are coherent phenomena that exist across all cultures or historic periods. The limited evidence for this is taken to mean that mental illnesses are somehow ‘socially constructed’

(Gergen, 2007). However, when it is claimed that mental illnesses are consistent phenomena, it is also assumed that there is just one form of sanity which everyone is expected to achieve, everywhere and always. The reflexive processes of the study have observed that the notion of individual self-seeking rational calculation is just as much ‘socially constructed’ as any mental illness. In the experiences of participants, the attainment of this ideal is prevented by those ‘determining factors.’ Participants encounter the facticity and the embodied nature of their being. Those who take on work roles in mental healthcare, for example, speak of being pulled into entrenched and competing commitments. There is never enough time or resources for them to achieve a rational response to the needs of the people they serve.

In setting aside the notion of the rational decider the study does not promote instead any notion that decisions are only an outcome of a person’s emotional disposition. Participants speak, for example, about the inconsistency of their emotions. Margaret Wetherell argues for an understanding of subjectivity in which she assumes “... *a reflexive actor embedded in relationally and inter-subjectively organized flows of practices, partly subject to pre-existing discursive resources, but endlessly mobilizing and reworking these.*” (Wetherell, 2005: 170). As a researcher who employs a reflexive process, I try to understand this complexity. Emotions are inter-subjective flows and temporary individual states, which I try to express through language, reworking pre-existing discursive resources; but how do I capture a stable sense of my identity?

As a worker in mental healthcare and a researcher I attempt to stand outside of the phenomena that I encounter. It might be expected that I should observe the true nature

of each individual person, defining the patterns of their emotional and cognitive states. My thoughts return to the metaphor of the 'sinking stone,' I could separate people and make them more solid. But in my own remote position of the impartial observer, I would have no substance. I wonder how, in reflexive awareness, should I experience myself, and I created the following fiction in contemplation of this question;

When I have met someone who appears intolerant, I have caught myself struggling to tolerate their hatred; I hate the way that they seem to feel superior to others and I tell myself I am better than that. I observe how critical they are, probably just one of their many faults. I dislike the manner in which they endlessly complain and I am often telling others how inappropriate this is. I judge them for being judgement, I shout at them because they are hostile, I put them in their place when they are oppressive. I can see just what is wrong with them and I just know that they have no insight into their faults. Then, when I accuse them, they confess their wrong doing; "Yes." they say; "We are not very good at admitting our faults." But perhaps I am misreading these situations, although that seems very unlikely.

I include this fiction as it reveals my intentions. I seek to promote equality of opportunity and freedom, to resolve conflicts by developing understanding. But my emotional engagement and my acting in the world pull me into ways of being with others that are not under my control. Participants in Chapter 8 fail in their efforts to find a way of being that is outside of the meanings imposed on them by others and perhaps I also fail in this enterprise. We can feel lost in an emotional flux, struggling to hold ourselves free of the constantly changing understandings imposed on us as we

relate to the dispositions of others. But it is this emotional stew, this social medium, within which our individual identities are formed. Mental health services are a formalised system in which authority is lent to our everyday positioning of others, when it seems that to maintain our social order some people must be held to be rational while others are understood as irrational.

Paradoxical exchanges of emotion are expressed when Anna, Frank and Peter in Chapter 5 make inconsistent decisions. Aside from their own untrustworthy state, they speak about a need to trust others. But where do trust or mistrust originate and in which person are they located? Also, Ben, Chris and Laurie feel that decisions are imposed on them and they are then missing out on life opportunities. But they do not talk about being rejected, speaking instead about rejecting society; so again, where is this rejection located? It might not be clear as to which party initiates a lack of trust or rejection in complex flows of emotion, but distance, fear and paranoia are evoked and a boundary is set between one person and another. Meanwhile participants who are employed as workers are expected to regulate the disturbed thoughts and feelings of others. But they talk about managing their own emotions while following the thinking of senior colleagues. It is difficult to locate the actions of mistrust, rejection, disturbed thoughts or feelings as the individual actor is a slippery character who evades our grasp, ebbing and flowing in a constant wash of emotions and meanings.

Does this study create new understandings?

The experience of making decisions is recognised in existential theory as an essential quality of being human. The nature of this decision-making is such that, with every option that is taken up, many others are lost. With each choice we make we tie

ourselves into evermore entrenched commitments. In these processes, two levels of decision-making are observed, as expressed in the writings of Soren Kierkegaard and Nikolai Berdyaev, for example, discussed by John Macquarrie (1973). At a fundamental and individual level, it is suggested that each of us can choose actions which are perceived of as right or wrong in the moral judgements of our peers. We can reject these external forms of discipline, in going our own way. But alternatively, by conforming to the expectations of others, we can choose to take up a position as a reasonable and rational decider, in professional, family or friendship networks. If we have chosen a position within a moral social order, our decisions at this level of functioning can appear to be a routine outcome of institutionalised processes, rather than a carefully examined personal choice.

Perhaps, by developing skills, engaging in valued social roles and forming mutually advantageous alliances with others, our freedom is enhanced. But, as we commit to agreements and meet expectations, it is easy to lose track so that evermore complex connections tie us down. These connections are built in mental healthcare through policies, routines, procedures; even in the structure of buildings with patient and 'staff only' areas, along with the gaze of professional record keeping. The accounts given across the analysis chapters reveal that some participants experience themselves as occupying positions within these systems while others resist or feel that they stand outside. Taking up these positions is not a simple matter of individual choice. Employment as an occupational therapist is a position Emma 'fell into by mistake,' for example (Chapter 6, pp. 179).

Aligning with the flow

Participants who are employed in mental healthcare feel pulled into commitments with the people they are trying to help, while also meeting service targets and changing their own being to fit in with these different agendas. I am one of these workers and we might experience ourselves at one moment as meeting the agendas of our employing organisations, like any other worker, then at another time we might place emphasis on our own mental health problems in which we have good and bad days, like the people we are trying to help.

Aligning with others who hold different positions in an institutional system can cause inconsistency in the experience of one's self. While also, the nature of that self can become contentious and alignment is not always successful. Peter, for example, describes his experience of depression and is concerned that if he is honest about his struggle to manage his moods, his managers will exclude him, while his immediate colleagues might exclude him if he is not honest (Chapter 5, pp. 150 / 164).

When participants are understood as aligning themselves with others, a new metaphorical construction is possible. The flow of this mirroring is similar to the movement of a shoal of fish, or a flock of birds. By making similar choices people come together in groups which constantly form and dissolve. But a person will find that this unpredictable movement can leave them for a moment on the periphery. Exposed in this manner they might make choices which cause them to be weighed down by their individuality, as meanings are attached to their person. They are suddenly different or deviant in some way. Peter is aware of these possibilities and he describes how, in his work team, he makes decisions which are 'reflected off other

people' (Chapter 5, pp. 142). Greta is critical of workers when she cannot engage with them as individuals, when they make decisions as a part of their work based system. However, Peter describes how he might be 'moved out of the organisation' if his decisions are not in line with that which is expected by his managers (Chapter 5, pp. 149).

Ian describes how he tried to help a suicidal woman and he is suddenly exposed, appearing to be neglectful and uncaring (Chapter 6, pp. 189). He might become knowable as an 'uncaring nurse.' This is an understanding of his disposition as fixed and influencing his choices. This interpretation could be elaborated though the use of notions such as 'depersonalisation,' 'burn-out,' or 'compassion fatigue.' However, locating problems, as if they are illnesses or flawed personality traits acting within individuals, is not likely to enable the recovery of a supposed pre-existent rational decider. Meanwhile this position is actively avoided by Chris, when he aligns with his friends in smoking cannabis; although he might then be placed as 'undeserving,' because he is causing his 'drug induced psychosis' (Chapter 8, pp.256).

Within these different interpretations participants are one moment rational and another they are mentally ill. They are caring, professional, impulsive, emotionally cold, over-involved, unreliable, following procedures, threatening, neglectful, holding a person's hand, excluded and burnt out: all moment by moment. Participants can engage with this immediacy in their sense of being, going with the flow and expressing complex understandings. Or they can try to cling to a fixed form of meaning which limits who they are and what they can be.

It is not my intention that the understanding gained through this study should just sit on the library shelf and make us all feel more secure. These understandings have changed me and it is no longer possible for me to accept simple interpretations in my work in mental healthcare. I am more aware of the dilemmas people face and the emotional flows in which they are caught. The actions of dampening emotions down and tidying people up no longer seem appropriate. It is important that emotional responses are stirred up and concerns are raised, heightening our emotional responses to the world. Emotions are at the same time, personal experiences, biological processes, inter-personal communications, performances and much more. They are prompted by a systemic process running between the individual, the world and other people. There is within us a primitive community, not a primitive individual (Merleau-Ponty 1962: 203).

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An interview schedule:

To structure interviews and help participants to talk freely on the topic, the following ‘scene setting questions,’ ‘prompt questions’ and ‘gap filling questions’ will be used. Some variation is included to explore experiences of ‘mental illness,’ ‘caring’ and ‘professional working.’

Scene setting questions:

I would like you to think about a time when you faced an important decision in your life.

I would like to find out about an occasion when an important decision was made about your care treatment.

Could you think about the decisions that have been made about the care and treatment of your relative.

Could you think about the decisions that you make about the care and treatment of your service users.

Prompts: Consider: starting or leaving a job, starting or ending a relationship, buying an expensive product, starting a college course, starting or stopping a habit such as alcohol, cigarettes or other drugs, having an operation, going on holiday, joining a religious group or political party.

Consider: prescribing medication, referring for assessments or psychotherapy or receiving referrals, admitting to psychiatric hospital.

Gap filling questions:

1. Did someone keep a record of the decision; why was the record made?
2. Did other people put pressure on you, trying to influence a decision that you made; how did you resist, or did you give in?
3. Have there been situations where other people have helped you to make a decision that you had been struggling with?
4. Are there times or situations in which you feel more able to made decisions?
5. Was your choice limited by practical constraints such as money, time or resources?
6. Have you ever worked through a list of pros and cons?
7. Did you have the feeling that you were negotiating with other people in reaching an agreement?